No. ____

In the Supreme Court of the United States

STATE OF ARKANSAS,
Petitioner,
v.
CHARLES GRESHAM, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Social Security Act authorizes the Secretary of Health and Human Services to approve "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of a host of state-administered welfare programs including Medicaid. Here, Arkansas sought approval to test the hypothesis that conditioning Medicaid expansion benefits on work, education, or volunteering would lead to healthier outcomes for its beneficiaries. The Secretary agreed, predicting that Arkansas's proposal would likely improve beneficiary health and promote independence from governmental support.

On review, the United States Court of Appeals for the D.C. Circuit held that approval unlawful. It did not hold that the Secretary's prediction of health benefits was unreasonable, or even that the Secretary failed to weigh those benefits against the project's potential costs. Rather, it held the Secretary could not even consider them because, in its view, the objective of Medicaid is expanding the ranks of those on Medicaid and beneficiary health is beyond the Secretary's remit.

The question presented is:

Whether the Secretary's approval of the Arkansas Works Amendment was lawful.

PARTIES TO THE PROCEEDING BELOW

Petitioner is the State of Arkansas. It was intervenor-defendant-appellant in the court of appeals.

The following respondents were plaintiff-appellees in the court of appeals: Charles Gresham, Cesar Ardon, Marisol Ardon, Adrian McGonigal, Veronica Watson, Treda Robinson, Anna Book, Russell Cook, and Jamie Deyo.

The following respondents were defendant-appellants in the court of appeals: the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), an agency of HHS, Alex M. Azar II, in his official capacity as the Secretary of HHS, and Seema Verma, in her official capacity as the Administrator of CMS.

RELATED PROCEEDINGS

Gresham v. Azar, No. 18-1900 (D.D.C.) (judgment entered Apr. 4, 2019).

Gresham v. Azar, No. 19-5094 (D.C. Cir.) (judgment entered Feb. 14, 2020).

Gresham v. Azar, No. 19-5096 (D.C. Cir.) (judgment entered Feb. 14, 2020).

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

CASES Page(s)

TABLE OF AUTHORITIES—Continued

STATUTES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

PETITION FOR A WRIT OF CERTIORARI

Petitioner the State of Arkansas respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The court of appeals' opinion (Pet. App. 1a-20a) is reported at 950 F.3d 93. The district court's order (Pet. App. 21a-60a) is reported at 363 F. Supp. 3d 165.

JURISDICTION

The court of appeals entered judgment on February 14, 2020. On March 19, 2020, this Court extended the deadline to file any petition for a writ of certiorari to 150 days from the date of the lower court judgment. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory provisions are set forth in the appendix to this petition (Pet. App. 193a-202a).

STATEMENT

A. Statutory Background.

1. The Medicaid Program.

In 1965, Congress enacted Medicaid to provide health care coverage to four categories of low-income people: the disabled, the blind, the elderly, and needy families with dependent children. Pet. App. 3a (citing 42 U.S.C. 1396-1). From its inception, Medicaid has been a cooperative federalism program. States administer the program under plans approved by the Secretary,

42 U.S.C. 1396a(b), and in return, States receive federal funding. 42 U.S.C. 1396b. Every State participates in Medicaid. *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 567 U.S. 519, 542 (2012).

In the decades after Medicaid's enactment, Congress slowly expanded Medicaid eligibility to include other particularly needy groups, including pregnant women and certain children. *Id.* at 583.

But in 2010, Congress "transformed" Medicaid. *Id.* Enacted as part of the Affordable Care Act, what came to be known as the Medicaid expansion made every adult with an income up to 133 percent of the poverty level eligible, and conditioned State participation in traditional Medicaid on covering the new expansion population. *Id.* at 542. In *NFIB*, this Court, reasoning the expansion was "a new health care program," not "a mere alteration of [the] existing" one, held that condition was unconstitutionally coercive. *Id.* at 584-85.

As a result, a State's participation in the Medicaid expansion is voluntary. *Id.* at 585. And many States have opted not to participate. *See Status of State Action on the Medicaid Expansion Decision*, Kaiser Fam. Found. (July 1, 2020).[1]

2. Demonstration Projects.

In 1962, concerned that the Social Security Act's various state plan requirements "often stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients," S. Rep. No. 87-1589, at 19 (1962) (Conf. Rep.), Congress enacted Section 1115 of the Social Security Act. Public Welfare Amendments of

[1] https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

1962, Pub. L. No. 87-543, sec. 122, 76. Stat. 172, 192 (1962) (codified as amended at 42 U.S.C. 1315). That section provides that "the Secretary may waive compliance with any of the requirements" of a host of state-administered public-assistance programs, including Medicaid, "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of those programs. 42 U.S.C. 1315(a).

As the Secretary has explained, demonstration projects "introduc[e] new approaches that can be a model for other States and lead to programmatic changes nationwide." Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11,678, 11678 (Feb. 27, 2012). For example, decades before Congress imposed work requirements as part of comprehensive welfare reform, States used Section 1115 demonstration projects to experiment with similar requirements. *See Aguayo v. Richardson*, 473 F.2d 1090, 1093-96 (2d Cir. 1973) (Friendly, J.) (upholding such a project); Anthony Albanese, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today*, 128 Yale L.J. Forum 827, 833-34 (2019) (describing these "precursor[s]" to welfare reform under the Bush and Clinton administrations).

The Medicaid expansion itself also began as a series of demonstration projects that expanded Medicaid coverage to then-ineligible populations. *See Spry v. Thompson*, 487 F.3d 1272, 1274-75 (9th Cir. 2007) ("States may also create 'experimental, pilot or demonstration' projects to serve 'expansion populations'—individuals who . . . are counted for federal reimbursements only because of the Secretary's waiver."). Indeed, Massachusetts' "Romney-care," which inspired the

Affordable Care Act's mandate and exchanges, was such a project, "funded and facilitated by a Medicaid demonstration waiver." Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 Stan. L. Rev. 1689, 1722 (2018).

Moreover, each of the last three administrations has approved Section 1115 waivers designed to test healthy behavior incentives. *See The Use of Healthy Behavior Incentives in Medicaid*, Medicaid & CHIP Payment & Access Comm'n 2, 7 (August 2016).[2] And many of those experiments—like the Arkansas Works amendment—conditioned some aspect or level of coverage on healthy behavior. *See id*.

B. Arkansas Works

In 2013, Arkansas became the first State in the country to receive a Section 1115 waiver to implement the Medicaid expansion. Gluck & Huberfeld, *supra* at 1737. Rather than enrolling beneficiaries in traditional Medicaid, Arkansas's expansion plan enrolled beneficiaries in private insurance plans, with the State paying the premiums. *See* Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. 1 (Sept. 27, 2013).[3] This first-in-the-nation public-private partnership was immediately successful—cutting the State's uninsured rate almost in half and reducing hospitals' uncompensated care losses by more than 50 percent. *Arkansas Private Option 1115*

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[2] https://www.macpac.gov/wp-content/uploads/2016/08/The-Use-of-Healthy-Behavior-Incentives-in-Medicaid.pdf.

[3] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-app-ltr-09272013.pdf.

Demonstration Waiver: 2014 Annual Report, Ark. Dep't of Human Servs. 3 (2015).[4]

In 2016, Arkansas received further waiver authority with the Secretary's approval of the Arkansas Works demonstration project. Building on its 2013 demonstration project, Arkansas Works provided premium support for expansion beneficiaries on employer-sponsored insurance; required beneficiaries above poverty level to pay premiums; incentivized annual checkups with additional benefits; and, critically for these purposes, referred all enrollees to the Arkansas Department of Workforce Services for job training and placement assistance. *See* Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., to Cindy Gillespie, Dir., Ark. Dep't of Human Servs. 1 (Dec. 8, 2016);[5] Arkansas 1115 Waiver Extension Application 10-14 (June 28, 2016).[6] The State expected that "as individuals receiving this referral bec[a]me employed . . . many [would] transition out of the Arkansas Works program to [employer-sponsored insurance] and private, individual market coverage." *Id.* at 14.

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[4] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-annl-rpt-2014.pdf.

[5] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-amndmnt-appvl-12292017.pdf.

[6] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-application-07072016.pdf.

Like Arkansas's original demonstration program, Arkansas Works was successful at reducing the State's uninsured population. But the work-referral program was a disappointment. Though a quarter of beneficiaries who acted on the referrals obtained employment, only 4.7 percent of beneficiaries acted on the referrals. Dist. Ct. R. 39-2 at 2. As a result, Arkansas concluded that a stronger incentive was necessary.

Therefore, in 2017, Arkansas proposed an amendment to Arkansas Works. Its centerpiece was a community-engagement requirement, designed to "promot[e] personal responsibility and work," "encourag[e] movement up the economic ladder, and facilitate[e] transitions from Arkansas Works to employer-sponsored and [exchange] coverage." Pet. App. 192a. To receive Medicaid expansion coverage, non-exempt, able-bodied beneficiaries under the age of 50 were required to report 80 hours of work, work-related activities, education, or volunteering per month. Pet. App. 111a-115a.

To avoid coverage loss, Arkansas carefully designed a requirement that was attainable and could be complied with in a variety of ways. Beneficiaries with minor dependents, full-time students, pregnant women, the medically frail, and many others were exempted. Pet. App. 112a-113a. Attendance at educational programs, including GED classes, counted towards the 80-hour requirement. Pet. App. 114a. So too did vocational training and up to 40 hours per month spent *looking* for work. Pet. App. 114a. And the hourly minimum wage was used as a proxy for work hours; thus, 40 hours of work at a wage twice the minimum would count as 80 hours. Pet. App. 113a n.2. Moreover, beneficiaries would only be considered non-compliant and lose their benefits if they failed to meet the requirement for three consecutive months. Pet. App.

117a. And non-complaint beneficiaries could reapply for benefits the next calendar year. Pet. App. 118a.

In March of 2018, after notice and comment, the Secretary, acting through the Administrator of CMS, approved Arkansas's proposed amendment. Pet. App. 65a. In contrast to previous Section 1115 approvals, the Secretary issued a detailed letter responding to commenters' concerns and explaining why he concluded the amendment would likely assist in promoting the objectives of Medicaid. Pet. App. 66a-79a.[7]

The Secretary predicted that the community-engagement requirement would likely promote two Medicaid objectives. First, the Secretary explained that the agency had "an obligation to ensure that proposed demonstration programs are likely to . . . improve health and wellness." Pet. App. 69a. Citing studies finding that work and other forms of community engagement are correlated with improved health, the Secretary predicted the community-engagement requirement would promote beneficiary health by encouraging community engagement. Pet. App. 70a. Second, looking to Medicaid's stated objective of "help[ing] individuals and families attain or retain capability for independence or self-care," Pet. App. 69a,[8] the Secretary found "it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means . . . to promote beneficiary independence." Pet. App. 75a.

Responding to commenters' concerns that the community-engagement requirement would result in

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[7] For examples of Section 1115 approvals under the prior administration, *see* D.C. Cir. J.A., Vol. I, at 118-21, 127-29, 137-40, 147-48.

[8] *See* 42 U.S.C. 1396-1 (listing that as an objective of Medicaid appropriations).

coverage loss rather than increased community engagement, the Secretary noted that Arkansas exempted beneficiaries who were unable to work; that his approval required the State to reach out to beneficiaries and explain how to comply and report compliance; and that beneficiaries would only lose coverage after receiving three notices over three months that their failure to satisfy the requirement placed their coverage in jeopardy. Pet. App. 73a-76a.

All things considered, the Secretary concluded that the requirement "create[d] appropriate incentives for beneficiaries to gain employment" and predicted that "the overall health benefits to the effected population through community engagement outweigh the health risks to those who fail to [comply] and who fail to seek exemption." Pet. App. 75a, 76a. But the Secretary cautioned that if he was mistaken and the community-engagement requirement did "not adequately incentivize beneficiary participation," he could withdraw Arkansas's waiver. Pet. App. 75a.

C. Procedural History

Several months after the Secretary approved the Arkansas Works Amendment, the District Court for the District of Columbia held the Secretary's approval of a similar Section 1115 demonstration project in Kentucky was arbitrary and capricious. *See Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018). In that case, Kentucky had predicted for budgetary purposes that under its project, its Medicaid expansion plan would cover 95,000 fewer people. *Id.* at 247. Though it is doubtful that this figure reflected expected coverage losses rather than transitions to commercial and employer-sponsored coverage, the district court attributed it entirely to the former and faulted the Secretary for

failing to address Kentucky's supposed estimate of coverage loss. *See id.* at 262-64.

Emboldened by that decision, a group of Arkansas Works beneficiaries filed suit in the same district court and designated this case as related to *Stewart*. Dist. Ct. R. 2. They claimed that the Arkansas Works Amendment's approval was arbitrary and capricious under that court's reasoning in *Stewart*—though Arkansas made no comparable estimate of a reduction in Medicaid expansion rolls. Pet. App. 31a, 35a. Arkansas intervened to defend its program. Pet. App. 32a.

As in *Stewart*, the district court concluded the Secretary's approval was arbitrary and capricious.

First, while "express[ing] skepticism that health, generally construed, was properly considered an objective" of Medicaid at all, Pet. App. 45a, or that Medicaid had *any* objectives beyond maximizing coverage, the district court ultimately only held that providing healthcare coverage to eligible beneficiaries was at least *a* Medicaid objective. Pet. App. 38a. Second—while not questioning the Secretary's predictions that Arkansas's project would promote beneficiary health and independence—the district court held, as in *Stewart*, that the Secretary said too little about coverage. In particular, the district court concluded that although the Secretary had "acknowledg[ed]" and addressed "at several points" comments predicting coverage losses, the Secretary had "fail[ed] to address whether coverage loss would occur." Pet. App. 40a. That supposed omission, the district court concluded, rendered his approval arbitrary and capricious. Pet. App. 50a.

Arkansas and the federal defendants appealed. The court of appeals affirmed, but on largely different grounds. It agreed with the defendants that—under

long-established circuit precedent the district court did not cite—when multiple statutory "objectives could point to conflicting courses of action," an "agency could give precedence to one or several objectives over others without acting in an arbitrary or capricious manner." Pet. App. 18a (citing *Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999) (Ginsburg, J.); *Melcher v. FCC*, 134 F.3d 1143, 1154 (D.C. Cir. 1998) (Wald, J.)). Thus, the court of appeals suggested, if Medicaid had "a laundry list" of purposes, one of which was beneficiary health, prioritizing beneficiaries' health over maximizing their ranks would have been permissible. Pet. App. 19a.

But the court of appeals declared that Medicaid was *not* a multi-purpose program. Pet. App. 16a. Instead, it held that Medicaid has just "one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." *Id.* And remarkably, the court of appeals concluded that "the alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid." *Id.*

The court of appeals based its novel interpretation of the Medicaid statute on an equally novel approach to statutory interpretation. It acknowledged that "the Medicaid statute does not have a standalone purpose section like some social welfare statutes" in the Social Security Act. Pet. App. 10a. But the court of appeals found what it deemed a statement of purpose in Medicaid's "appropriations provision" at Section 1901 of the Act. Pet. App. 10a-11a (citing 42 U.S.C. 1396-1). That section, enacted in 1965, states an *appropriations* purpose of providing "medical assistance on behalf of [needy] families with dependent children and

of aged, blind, or disabled individuals"—that is, the original groups of Medicaid beneficiaries. Given that section, and the statute's definition of medical assistance as medical services or payment for them, Pet. App. 11a (citing 42 U.S.C. 1396d(a)), the court of appeals concluded the entire program's "primary objective" was "unambiguously" coverage. Pet. App. 12a (quoting *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984)).

Having discovered an exhaustive statement of Medicaid's purposes in its 55-year-old appropriations section, the court of appeals readily dismissed health and independence as "non-statutory objectives." Pet. App. 19a. As to health, the court of appeals simply noted that Section 1901 "makes no mention" of it. Pet. App. 13a. Though granting that health might be "the ultimate purpose[]" of Medicaid's provision of health care coverage, the court of appeals reasoned the Secretary was bound by "the means [Congress] has deemed appropriate, and prescribed, for the pursuit" of that purpose—even when acting under a statute that authorizes waiving any and all of Medicaid's substantive requirements in pursuit of its objectives. Pet. App. 13a (quoting *MCI Telecomms. Corp. v. AT&T Co.*, 512 U.S. 218, 231 n.4 (1994)).

As for financial independence, the court of appeals questioned whether the Secretary had relied on that objective in approving the Arkansas Works Amendment, asserting that it was absent from the "specific section" of the Secretary's approval addressing Medicaid objectives and appeared only in responses to comments. Pet. App. 14a. Ultimately, however, the court of appeals concluded that financial independence too was non-statutory. Here, the court of appeals encountered a problem: the appropriations section it deemed an

unambiguously exhaustive statement of Medicaid's purposes *says* a purpose of Medicaid appropriations was to "help [traditional Medicaid beneficiaries] attain or retain capability for independence or self-care." Pet. App. 11a (quoting 42 U.S.C. 1396-1). Yet the court of appeals simply sidestepped that problem by declaring in a single sentence that the independence Congress had in mind was "functional independence," not "financial independence from government welfare programs." Pet. App. 15a.

Having determined the Secretary's approval pursued "an entirely different set of objectives than the one we hold is the principal objective of Medicaid," Pet. App. 18a, the conclusion that his approval was arbitrary and capricious necessarily followed.

Unlike the district court, the court of appeals did not claim that the Secretary said nothing about coverage loss. It acknowledged that the Secretary pointed to features of Arkansas's project that would mitigate coverage loss, said he could rescind his approval if greater loss occurred than he expected, and predicted that the health benefits of the project would outweigh the harms of coverage losses. Pet. App. 17a-18a. But given its conclusion that coverage was essentially the program's sole objective, the court of appeals deemed these statements an inadequate, "conclusory" treatment of the problem. Pet. App. 18a.

Ultimately, however, the court of appeals' problem with the Secretary's approval was more fundamental: in predicting that the risks of coverage loss, no matter how slight, would be outweighed by the project's health benefits, the Secretary "prioritize[d] non-statutory objectives [over] the statutory purpose." Pet. App. 19a.

REASONS FOR GRANTING THE WRIT

I. The court of appeals' decision is wrong.

A. Health and independence are Medicaid objectives.

1. Section 1901 is not a statement of the Medicaid expansion's objectives.

If Medicaid's sole objective were maximizing eligible beneficiaries' coverage, then under the court of appeals' reasoning no experimental work or community-engagement requirement would ever be permissible. After all, all such requirements trade *some* risk of coverage loss to achieve healthier outcomes and independence. And under the court of appeals' logic, that will always be an impermissible tradeoff since Medicaid's sole objective is maximizing coverage.

Simply covering eligible beneficiaries, however, is not Medicaid's sole objective. So the Secretary may balance it against others, as indeed every administration this century, in exercising its Section 1115 waiver powers, has done.

The court of appeals' contrary conclusion was based on the original Medicaid's appropriations section. It read that provision as an exhaustive—and unambiguously so—statement of Medicaid's purposes. There are two problems with that interpretation. *First*, that section is just an authorization of appropriations, not a purpose section. *Second*, it says nothing about the purposes of the ACA's Medicaid expansion, or for that matter, any of Medicaid's other expansions since its enactment. Rather, at best, it only speaks to the original Medicaid's purposes.

a. *Section 1901 is not a statement of programmatic objectives.*

Enacted in 1965, and last substantively amended in 1973,[9] Section 1901 says:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

42 U.S.C. 1396-1.

That section is a surpassingly odd place to find a statement of programmatic objectives. Congress normally states agency objectives—including for social welfare programs—in a purpose section. *See, e.g.*, 42 U.S.C. 601(a) (TANF's "Purpose" section, stating "[t]he

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[9] That amendment substituted "disabled" for the provision's original reference to the "permanently and totally disabled." Pub. L. No. 93-233, sec. 13(a)(1), 87 Stat. 947, 960 (1973). A later technical amendment struck its reference to the former Department of Health, Education and Welfare. Pub. L. No. 98-369, sec. 2663(j)(3)(C), 98 Stat. 494, 1171 (1984).

purpose of this part"); 42 U.S.C. 1397aa(a) (SCHIP's "Purpose" section, stating "[t]he purpose of this subchapter"). But as the court of appeals acknowledged, Section 1901 is not such a section. Pet. App. 10a.

The court of appeals suggested that Section 1901 at least "articulates the reasons underlying the appropriation of funds," thus instructing the Secretary on the objectives to pursue in spending them. Pet. App. 10a-11a. But even this overstates matters. For Section 1901 does not appropriate funds; Medicaid funding is appropriated annually in Congress's budgets. *See, e.g.*, Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, div. A, tit. II, 133 Stat. 2534, 2568 (2019). All Section 1901 does is "authorize[] [funds] to be appropriated," 42 U.S.C. 1396-1—a crucial nuance that sharply limits its role.

Often when Congress appropriates funds for a program, it "passes an Act authorizing" itself to appropriate in between creating the program and appropriating funding for it. *Me. Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1319 (2020) (citing U.S. Gov't Accountability Office, GAO-16-464SP, *Principles of Federal Appropriations Law* 2-56 (4th ed. 2016) (GAO Redbook)). These authorizations are parliamentary formalities, enacted to comply with House rules that require appropriations in appropriation bills to have been previously authorized by law. *See* GAO Redbook 2-55; James V. Saturno & Brian T. Yeh, Cong. Res. Serv. R42098, *Authorization of Appropriations: Procedural and Legal Issues* 4, 6-7 (2016) ("*Authorization of Appropriations*").

While authorizations serve a useful parliamentary role, they do not speak to agencies. Rather, an authorization like Section 1901 is only a "directive to *Congress itself*" that "serves little purpose other than

to comply with House Rule XXI," the rule requiring pre-appropriation authorization. GAO Redbook 2-56 (emphasis added). Congress directs agencies on how to spend appropriated funds through programs' organic statutes, or appropriations provisions themselves, not through appropriation authorizations—and it did so in Medicaid. *See* 42 U.S.C. 1396b(a) (directing the Secretary to fund States' Medicaid plans); Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, div. A, tit. II, 133 Stat. 2534, 2568 (2019) (same). So while Section 1901 might state Congress's purposes for authorizing *itself* to make Medicaid appropriations more than 50 years ago, it doesn't tell the Secretary what purposes to pursue.

Besides Section 1901's function, its text also indicates it wasn't intended to fully state Medicaid's purposes. Again, Section 1901's first sentence says that "For the purpose of enabling each State . . . to furnish (1) medical assistance on behalf of [Medicaid's original beneficiaries], and (2) rehabilitation and other services to help [them] attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out *the purposes of this subchapter*." 42 U.S.C. 1396-1 (emphasis added). If "the purpose" stated in the sentence's long preamble *were* the sole "purposes of this subchapter," Congress wouldn't have referred more broadly to "the purposes of this subchapter," as though there were others. It would have simply said "that purpose" to refer back to the one stated.

That it didn't makes perfect sense. Had Congress only authorized appropriations to carry out the purposes it listed in 1965, appropriations for new Medicaid beneficiaries and objectives to come might have been seen as unauthorized. By explicitly acknowledging

"purposes of this subchapter" beyond the ones it listed, Congress wrote an authorization that could last.

b. *Section 1901 does not state the purposes of the Medicaid expansion.*

Even if Section 1901 were a statement of purpose, it would only explain original Medicaid's purposes. Section 1901 states a purpose of providing medical assistance to the four original Medicaid populations—needy "families with dependent children" and "aged, blind, or disabled individuals"—and a purpose of helping "such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. 1396-1.

But as Section 1901 predates the Medicaid expansion by nearly half a century, it understandably says nothing about the program's objectives for expansion beneficiaries: childless, non-disabled adults up to 133 percent of the poverty level. Indeed, if that section stated Medicaid's sole objectives, then even covering expansion beneficiaries would exceed Medicaid's objectives since it only discusses assisting "families with dependent children" and "aged, blind, or disabled individuals." *Id.* Thus, looking to the "original program['s]" appropriations section to find the objectives of the expansion's "new program," *NFIB*, 567 U.S. at 582, 583, makes little more sense than searching for the Medicaid's expansion's objectives in the Medicare Act.

The court of appeals did not grapple with this problem. Instead, it simply applied the section's purpose to the Medicaid expansion as if the language limiting them to original Medicaid beneficiaries weren't there. But a court cannot simply "read words out the statute." *Barber v. Thomas*, 560 U.S. 474, 490 (2010). Nor can it unilaterally extend that provision's reach to expansion beneficiaries: "To supply omissions

transcends the judicial function." *Nichols v. United States*, 136 S. Ct. 1113, 1118 (2016).

By contrast, the district court, at least, recognized this problem. In *Stewart*, it suggested that the omission of expansion beneficiaries from Section 1901 was another ACA "example[] of inartful drafting," and that they should simply be read into that provision alongside their original-Medicaid counterparts. *Stewart*, 313 F. Supp. 3d at 269 (quoting *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015)). And once so read in, that section would state the expansion's purposes.

The district court's argument for that conclusion, however, was simply question-begging. It claimed that "it [was] inconceivable that Congress intended to establish separate Medicaid programs, with differing purposes." *Id.* at 270; Pet App. 46a (reaffirming that conclusion).

But that's hardly the case. For one thing, contrary to the district court's suggestion that original and expansion Medicaid are the same program, *NFIB* explicitly held that the two are *different* programs. *See* 567 U.S. at 582 ("We cannot agree that existing Medicaid and the expansion dictated by the Affordable Care Act are all one program . . . ."). And for another, it is hardly "inconceivable" that Congress had somewhat different purposes in mind when it created programs targeted at very different populations—nondisabled, childless adults vs. the aged, blind and disabled—nearly half a century apart. Nor is it "inconceivable" that the same Congress that mandated cash incentives under Medicaid for weight loss, *see infra* at 21, had a different view on the direct pursuit of health than the body that enacted original Medicaid.

Because the district court did not consider Section 1901's limited role as an authorization of appropriations, it did not make what may seem a better argument for its rewrite of Section 1901: that expansion beneficiaries must be read into that provision to authorize expansion funding. That argument, however, would also fail, because expansion funding has no shortage of authorization as things stand. And even if it lacked authorization, that would not cause the expansion's appropriations to fail.

First, Section 1901 itself authorizes appropriations "to carry out the purposes of this subchapter," which assuredly include operating the expansion program codified there. 42 U.S.C. 1396-1. Its lengthy preamble only states Congress's original reason for authorizing funding; it does not limit the authorization. Second, even under House and Senate rules, an organic statute authorizing expenditures—as the Medicaid Act does regarding the expansion—suffices to authorize appropriations; provisions like Section 1901 are not required. *See Authorization of Appropriations*, *supra*, at 4, 6-7. Third and last, pre-appropriation authorization is only a parliamentary requirement, not a legal one, and one that Congress often flouts. *See id.* at 8-9; GAO Redbook 2-80 n.72 ("Congress appropriates huge sums each year to fund programs with expired authorizations.").

It is little wonder, then, that as Congress expanded Medicaid "on more than 50 occasions" from the 1980s to 2010, *NFIB*, 567 U.S. at 627 (Ginsburg, J.), it never amended the authorization to name the new beneficiaries: doing so would have been entirely unnecessary. Thus, it is impossible to conclude "beyond question"—as courts must before judicially correcting statutes—that Section 1901's silence on the Medicaid expansion's

purposes was a drafting error. *U.S. Nat'l Bank of Ore. v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 462 (1993).

In sum, then, Section 1901 is silent on the Medicaid expansion's purposes. And there is no basis to judicially correct its statement of original Medicaid's appropriations' purposes to state the purposes of expansion funds. So Section 1901 did not, unambiguously or otherwise, preclude the Secretary from deeming health and independence objectives of the Medicaid expansion.

2. The Secretary properly considered health and independence.

Absent the court of appeals' erroneous conclusion that Section 1901's preamble provides an exhaustive list of Medicaid's purposes, there isn't any real dispute that beneficiary health and independence are Medicaid objectives. Indeed, even if coverage were Medicaid's sole objective, beneficiary health and independence would further coverage by freeing scarce Medicaid resources to cover the neediest beneficiaries.

First, as to health, health is undoubtedly an objective—indeed, the ultimate objective—of a health care program. After all, health is the purpose of health care. And if Medicaid were only about lightening beneficiaries' health care costs, as the district court suggested, *Stewart*, 313 F. Supp. 3d at 267, much of Medicaid would make no sense: from its provision that Medicaid plans must provide *care* with "reasonable promptness,"[10] 42 U.S.C. 1396a(a)(8), to its many pro-

[10] Indeed, in 2010 Congress amended the definition of "medical assistance," the lynchpin of the D.C. Circuit's analysis, to make it clearer that this provision required prompt care, not just prompt payment for it. *See* H.R. Rep. No. 111-299, pt. 1, at 649-50 (2009).

visions ensuring the quality of care, not just its coverage. *See, e.g.*, *id.* 1396a(a)(22), (a)(33)(A) (requirements for state plans); *id.* 1396n(a)(2)(B), (b)(1)-(2), (i)(1)(H)(i) (conditioning federal payment on quality assurance).

In response, the court of appeals concluded that although health might be "the ultimate purpose[]" of Medicaid, the program solely pursues that purpose through "the means" of "health care coverage." Pet. App. 12a. But that's an odd distinction to rest on here since Section 1115 expressly authorizes the Secretary, in approving demonstration projects, to waive *any* and *all* of Medicaid's substantive "requirements"—its means—to promote its "objectives." 42 U.S.C. 1315(a).

Moreover, the court of appeals' distinction ignores the fact that, as Medicaid has evolved since 1965, Congress has increasingly used it to pursue improved health outcomes directly. For example, in 2006, Congress *required* the Secretary to approve up to ten States' demonstration programs that contained "incentives to patients to seek preventive health care services"—including conditioning enhanced coverage on using those services. *Id.* 1396u-8(a)(3), (a)(3)(B). After an initial five-year testing period, the Secretary was authorized to approve such programs in any State. *Id.* 1396u-8(a)(2)(A)(ii). And in the ACA, Congress again mandated healthy behavior incentives, there through the Incentives for Protection of Chronic Disease in Medicaid program, which required the Secretary to fund experimental cash incentives for such "healthy behaviors" as weight loss or smoking cessation. Pub. L. No. 111-148, sec. 4108, 124 Stat. 119, 561-64 (2010) (codified at 42 U.S.C. 1396a (note)). If Congress thought so highly of healthy-behavior-incentive experiments that it mandated the Secretary try some, surely the Secretary at least has the discretion to try others.

As for independence, the Secretary's view that one objective of the Medicaid expansion—a public-assistance program for poor, able-bodied, non-elderly adults—is helping beneficiaries become independent from the program is hardly novel.[11] Any social welfare program for those who can work has that objective, and there is no reason to think the Medicaid expansion is any different. Indeed, even Section 1901, in which the court of appeals placed so much stock, said original Medicaid was intended to provide "services to help [beneficiaries] attain or retain capability for independence or self-care." 42 U.S.C. 1396-1. The court of appeals insisted this language unambiguously referred to "functional independence," apparently meaning the ability to live without nursing or home health care. Pet. App. 15a. But even original Medicaid wasn't limited to the disabled or elderly; it provided assistance to low-income "families with dependent children," and "services to help *such families* [and other beneficiaries] attain or retain capability for independence." 42 U.S.C. 1396-1 (emphasis added). Thus, the reference to independence could not have been limited in the way the court of appeals thought.

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[11] The court of appeals' suggestion that the Secretary did not rely on this objective at all was mistaken. While placing greater emphasis on health, the Secretary said "the agency has an obligation to ensure that proposed demonstration projects are likely to better enable states to serve their low-income populations, through measures . . . including [ones] to help individuals and families attain or retain capability for independence or self-care." Pet. App. 69a. He also described the purpose of the project as "test[ing] whether [the community-engagement requirement] will lead to improved health outcomes *and greater independence*," and ultimately concluded that "it furthers the objectives of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health *and to promote beneficiary independence*." Pet. App. 68a, 75a (emphasis added).

This Court has already recognized that conserving Medicaid costs by helping people avoid becoming eligible for Medicaid assistance is a Medicaid objective. In *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003), drug manufacturers claimed that Medicaid preempted a state law that required prior authorization for Medicaid purchases from manufacturers who declined to provide discounts for non-Medicaid purchases. A plurality of this Court upheld the law on the ground that the discounts served the "Medicaid-related goal[]" of keeping "borderline" people from suffering illness and "financial hardship" and "end[ing] up in the Medicaid program." *Id.* at 663. Justice Breyer concurred on the ground that the law "may further [that and other] Medicaid-related objectives," agreeing they were Medicaid objectives. *Id.* at 671 (Breyer, J., concurring in part and concurring in the judgment). And even the three Justices in dissent did not dispute that keeping borderline individuals off Medicaid assistance was a Medicaid objective; they only disputed whether the "facts in the record" showed the rebates had that effect. *Id.* at 689 (O'Connor, J., concurring in part and dissenting in part). If keeping the ineligible from becoming eligible serves a Medicaid objective, encouraging the eligible to attain employment that can help them become ineligible logically serves a Medicaid objective.

B. The Secretary's approval was not arbitrary and capricious.

Because health and independence are Medicaid objectives, the Secretary's approval was not arbitrary and capricious. The Secretary predicted that the Arkansas Works Amendment would likely promote beneficiary health and independence. Neither the district court nor court of appeals found that prediction

unreasonable. Under the court of appeals' approach below, that means the Secretary's approval was lawful. For under that approach, where a statute has "several possible objectives," it is "enough for the agency to assess at least one." Pet. App. 18a (citing *Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999) (Ginsburg, J.) ("When an agency must balance a number of potentially conflicting objectives . . . judicial review is limited to determining whether the agency's decision reasonably advances at least one of those objectives and its decisionmaking process was regular.")).

That approach to arbitrary-and-capricious review under a multi-objective statute is the correct one. As Judge Wald explained in one of the early decisions adopting that approach, "only the [agency] may decide how much precedence particular policies will be granted when several are implicated in a single decision." *MobileTel, Inc. v. FCC*, 107 F.3d 888, 895 (D.C. Cir. 1997). A court cannot decide how much weight the Secretary should give coverage relative to health. That would "substitute [its policy judgment] for that of the Secretary." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2569 (2019). Indeed, this Court held in *Department of Commerce* that where an agency's choice "call[s] for value-laden . . . weighing of incommesurables"—there, whether "the value of obtaining more complete and accurate citizenship data . . . was worth the risk of a potentially lower response rate"—that choice is the agency's to make. *Id.* at 2571. Here, similarly, the Secretary concluded that the health benefits of enhanced community engagement outweighed the risks of coverage loss. Pet. App. 76a-77a. How to weigh those incommensurables was likewise his prerogative.

Further, even if the Secretary were required to consider potential coverage losses beyond choosing to place greater weight in his decision on health benefits, the Secretary did consider coverage. As the court of appeals acknowledged, the Secretary responded to comments raising coverage, pointed to multiple features of Arkansas's project that would mitigate coverage loss, indicated he believed that the community-engagement requirement would "adequately incentivize beneficiary participation" as to avoid substantial coverage loss, Pet. App. 75a, and ultimately concluded that the likely health benefits of the project outweighed the risks of coverage loss.

What the court of appeals really faulted the Secretary for, then, was failing to estimate the amount of coverage loss. But while "[i]t is one thing to set aside agency action under the Administrative Procedure Act because of failure to adduce empirical data that can readily be obtained," "[i]t is something else to insist upon obtaining the unobtainable." *FCC v. Fox Television Stations*, 556 U.S. 502, 519 (2009). The Secretary could not predict the precise outcome of Arkansas's experiment, turning on the vagaries of human behavior as it did, without conducting the experiment first. As Judge Friendly wrote of Section 1115 approvals, "it is legitimate for an administrator to set a lower threshold for persuasion when he is asked to approve a program that is avowedly experimental and has a fixed termination date." *Aguayo v. Richardson*, 473 F.2d 1090, 1103 (2d Cir. 1973).

Again, *Department of Commerce* is helpful. There, the Secretary of Commerce, advised by his own Census Bureau that a citizenship question would depress response rates, concluded that given the "limited empirical evidence" to that effect, he could not "determine

definitively" whether the Bureau was right. 139 S. Ct. at 2563. He then concluded that the value of citizenship data outweighed the uncertain risks of lower response. *Id.* This Court did not require more; it found his "uncertainty" "justifiabl[e]," and his ultimate weighing reasonable. *Id.* at 2571. The Secretary's consideration of coverage here was no different. Faced with comments predicting coverage loss on the basis of surmise or the history of other programs, the Secretary found the potential for coverage loss uncertain and concluded that the benefits of approval outweighed the uncertain risks. The APA required no more.

II. The question presented warrants review.

In addition to Arkansas and Kentucky, eighteen other States have approved or pending Section 1115 waiver applications to experiment with community-engagement requirements in Medicaid. Under the decision below, which would almost certainly govern any challenges to those requirements, every one of those States' requirements would be invalid. Indeed, two of those eighteen have been struck down by the courts below already. And those are not the only States whose Section 1115 waivers are threatened by the court of appeals' decision. Rather, under that decision, any Section 1115 waiver that conditions coverage on any healthy behavior—not just work or community-engagement—is suspect. Certiorari is needed to review and reverse that dramatic curtailment of the Secretary's waiver powers and the States' ability to test new approaches to implementing Medicaid.

Under the decision below, no work- or community-engagement requirement approved under Section 1115 can survive, and none can be approved. All work- or community-engagement requirements seek to promote the health or financial independence, or both, of those

subject to them. And all such requirements at least create some theoretical risk of coverage loss. But under the decision below, the only thing the Secretary may consider in evaluating Section 1115 demonstration projects is coverage. Anything else—and in particular health and financial independence—is "non-statutory." Pet. App. 19a. That means that no Section 1115 approval of a work- or community-engagement requirement, no matter how careful its consideration of coverage, can survive the court of appeals' decision. For any such approval will, under that decision's logic, promote "non-statutory objectives" to at least the potential detriment of "the statutory purpose." Pet. App. 19a.

The government agrees. Since the court of appeals' decision, it has conceded that decision forecloses any defense of three Section 1115 approvals of community-engagement requirements in the courts below. In *Philbrick v. Azar*, 397 F. Supp. 3d 11 (D.D.C. 2019), the district court set aside the Secretary's approval of New Hampshire's community-engagement requirement. After the government appealed that decision, the court of appeals rendered the decision from which certiorari is sought here. Even though the government's approval and discussion of coverage in *Philbrick* was far more detailed than even the approval at issue here,[12] the government conceded its appeal was "controlled" by the decision below in this case. *Philbrick v.*

[12] *See* Letter from Mary C. Mayhew, Deputy Adm'r & Dir., Ctrs. for Medicare & Medicaid Servs., to Henry D. Lipman, Medicaid Dir., N.H. Dep't of Health & Human Servs. 1 (Nov. 30, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-granite-advantage-health-care-program-ca.pdf.

Azar, Nos. 19-5293, 19-5295, 2020 WL 2621222, at *1 (D.C. Cir. May 20, 2020).

In a second case, challenging the Secretary's approval of Michigan's community-engagement requirements, the Secretary conceded that under the decision below, his "approval of [Michigan's waiver's] work and community engagement component is unlawful." *Young v. Azar*, No. 1:19-cv-3526, D. Ct. Doc. 24, at 3 (D.D.C. Mar. 3, 2020). The district court subsequently entered judgment as to those requirements. *Young*, No. 1:19-cv-3526 (D.D.C. Mar. 4, 2020).

And in a third case, challenging Indiana's community-engagement requirements, the government conceded before the court of appeals even rendered judgment that, were it to rule in favor of Respondents, the Secretary's approval of Indiana's "community engagement requirement would be unlawful under circuit precedent." *Rose v. Azar*, No. 1:19-cv-2848, D. Ct. Doc. 31, at 1 (D.D.C. Jan. 6, 2020). Proceedings in that case are stayed pending the COVID-19 emergency, but the district court will inevitably vacate Indiana's approval once the stay is lifted.

Those three vacaturs will only be the beginning. The Secretary has approved community-engagement requirements in five more States: Arizona, Ohio, South Carolina, Utah, and Wisconsin. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, Kaiser Fam. Found. (June 26, 2020).[13] None of those approvals could survive a challenge in the court of appeals, and already some of those States have suspended implementation in view of the litigation below. *See* Letter from Jami Snyder, Dir., Ariz. Health

[13] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state.

Care Cost Containment Sys., to Calder Lynch, Deputy Adm'r & Acting Dir., Ctrs. for Medicare & Medicaid Servs. (Oct. 17, 2019).[14] Ten more States have pending applications to institute community-engagement requirements under Section 1115: Alabama, Georgia, Idaho, Mississippi, Montana, Nebraska, Oklahoma, South Dakota, Tennessee, and Virginia. *Medicaid Waiver Tracker*, *supra*. Unless this Court grants review of the decision below, the Secretary will be forced to deny all of those applications.

And even that does not exhaust the ramifications of the court of appeals' decision. Many other States have obtained Section 1115 waivers to condition coverage, in whole or part, on healthy behaviors. Michigan, for example, requires beneficiaries above 100 percent of poverty level to obtain a health risk assessment or engage in other healthy behaviors, such as getting vaccinations. The same plaintiffs who have challenged Michigan's community-engagement requirement have challenged that requirement as well. *See Young*, No. 1:19-cv-3526, D. Ct. Doc. 1, at 23-24, 47-48 (D.D.C. Nov. 22, 2019). Perhaps that requirement and others like it could be defended on the ground that the preventive care and other healthy behaviors they incentivize conserve Medicaid costs—an objective the decision below, at least explicitly, did not reject. But they are, at the least, extremely vulnerable to attack.

The harms of the decision below can scarcely be overstated. It is often said that the "States are laboratories for experimentation," *Hall v. Florida*, 572

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[14] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf.

U.S. 701, 724 (2014), but that is literally true under Section 1115. Indeed, much of national healthcare policy as we know it began its life as a State's Section 1115 Medicaid experiment. Yet under the court of appeals' decision, that flexible waiver authority to test policies that may enhance the health and welfare of a State's citizens—and ultimately the Nation's—would become a one-way ratchet, serving no purpose but to "experiment" with means of increasing coverage. The Court should grant review to restore Section 1115 to its central place in healthcare policymaking.

Finally, the absence of a circuit split does not counsel against certiorari. The D.C. Circuit does not have exclusive jurisdiction over challenges to Section 1115 approvals, and in theory plaintiffs could sue in their home States. But the conclusive bar the D.C. Circuit has erected to Section 1115 community-engagement requirements all but ensures that future plaintiffs will bring their challenges in the D.C. Circuit, rather than taking the risk that a different circuit would reject its erroneous interpretation of the Medicaid statute. And the district court below has resisted the government's requests to transfer venue to plaintiffs' home States, reasoning that venue in the District is preferable because "D.C.-based agency officials" process Section 1115 applications. *Stewart v. Azar*, 308 F. Supp. 3d 239, 247 (D.D.C. 2018). A split, therefore, is extremely unlikely to emerge. Only this Court's review of the decision below can reopen the door to Section 1115 innovation.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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July 13, 2020

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 19-5094
Consolidated with 19-5096

CHARLES GRESHAM, *et al*.,
Appellees

v.

ALEX MICHAEL AZAR, II, SECRETARY,
UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES IN HIS OFFICIAL CAPACITY, *et al*.,
Appellants

STATE OF ARKANSAS,
Appellee

Appeals from the United States District Court
for the District of Columbia
(No. 1:18-cv-01900)

Argued October 11, 2019
Decided February 14, 2020

Alisa B. Klein, Attorney, U.S. Department of Justice, argued the cause for federal appellants. With her on the briefs were *Mark B. Stern*, Attorney, *Robert P. Charrow*, General Counsel, U.S. Department of Health and Human Services, and *Brenna E. Jenny*, Deputy General Counsel.

Leslie Rutledge, Attorney General, Office of the Attorney General for the State of Arkansas, *Nicholas J. Bronni*, Solicitor General, *Vincent M. Wagner*, Deputy Solicitor General, and *Dylan L. Jacobs*, Assistant Solicitor General, were on the brief for appellant State of Arkansas.

Ian Heath Gershengorn argued the cause for plaintiff-appellees. With him on the brief were *Jane Perkins*, *Thomas J. Perrelli*, *Devi M. Rao*, *Natacha Y. Lam*, *Zachary S. Blau*, and *Samuel Brooke*.

Kyle Druding was on the brief for *amici curiae* American College of Physicians, et al. in support of plaintiffs-appellees.

Edward T. Waters, *Phillip A. Escoriaza*, and *Christopher J. Frisina* were on the brief for *amici curiae* Deans, Chairs, and Scholars in support of plaintiffs-appellees.

Judith R. Nemsick, *Jon M. Greenbaum*, and *Sunu Chandy* were on the brief for *amici curiae* Lawyers Committee for Civil Rights Under Law, et al. in support of appellees and affirmance.

Before: PILLARD, *Circuit Judge*, and EDWARDS and SENTELLE, *Senior Circuit Judges*.

Opinion for the Court filed by *Senior Circuit Judge* SENTELLE.

SENTELLE, *Senior Circuit Judge*: Residents of Kentucky and Arkansas brought this action against the Secretary of Health and Human Services. They contend that the Secretary acted in an arbitrary and capricious manner when he approved Medicaid demonstration requests for Kentucky and Arkansas. The District Court for the District of Columbia held that the Secretary did act in an arbitrary and capri-

cious manner because he failed to analyze whether the demonstrations would promote the primary objective of Medicaid—to furnish medical assistance. After oral argument, Kentucky terminated the challenged demonstration project and moved for voluntary dismissal. We granted the unopposed motion. The only question remaining before us is whether the Secretary's authorization of Arkansas's demonstration is lawful. Because the Secretary's approval of the plan was arbitrary and capricious, we affirm the judgment of the district court.

I. Background

Originally, Medicaid provided health care coverage for four categories of people: the disabled, the blind, the elderly, and needy families with dependent children. 42 U.S.C. § 1396-1. Congress amended the statute in 2010 to expand medical coverage to low-income adults who did not previously qualify. *Id.* at § 1396a(a)(10)(A)(i)(VIII); *NFIB v. Sebelius*, 567 U.S. 519, 583 (2012). States have a choice whether to expand Medicaid to cover this new population of individuals. *NFIB*, 567 U.S. at 587. Arkansas expanded Medicaid coverage to the new population effective January 1, 2014, through their participation in private health plans, known as qualified health plans, with the state paying premiums on behalf of enrollees. Appellees' Br. 14; *Gresham v. Azar*, 363 F. Supp. 3d 165, 171 (D.D.C. 2019).

Medicaid establishes certain minimum coverage requirements that states must include in their plans. 42 U.S.C. § 1396a. States can deviate from those requirements if the Secretary waives them so that the state can engage in "experimental, pilot, or demonstration project[s]." 42 U.S.C. § 1315(a). The section authorizes the Secretary to approve "any experi-

mental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. *Id.*

Arkansas applied to amend its existing waiver under § 1315 on June 30, 2017. Arkansas Administrative Record 2057 ("Ark. AR"). Arkansas gained approval for its initial Medicaid demonstration waiver in September 2013. In 2016, the state introduced its first version of the Arkansas Works program, encouraging enrollees to seek employment by offering voluntary referrals to the Arkansas Department of Workforce Services. Dissatisfied with the level of participation in that program, Arkansas's new version of Arkansas Works introduced several new requirements and limitations. The one that received the most attention required beneficiaries aged 19 to 49 to "work or engage in specified educational, job training, or job search activities for at least 80 hours per month" and to document such activities. *Id.* at 2063. Certain categories of beneficiaries were exempted from completing the hours, including beneficiaries who show they are medically frail or pregnant, caring for a dependent child under age six, participating in a substance treatment program, or are full-time students. *Id.* at 2080–81. Nonexempt "beneficiaries who fail to meet the work requirements for any three months during a plan year will be disenrolled . . . and will not be permitted to re-enroll until the following plan year." *Id.* at 2063.

Arkansas Works included some other new requirements in addition to the much-discussed work requirements. Typically, when someone enrolls in Medicaid, the "medical assistance under the plan . . . will be made available to him for care and services included under the plan and furnished in or after the third

month before the month in which he made application." 42 U.S.C. § 1396a(a)(34). Arkansas Works proposed to eliminate retroactive coverage entirely. Ark. AR 2057, 2061. It also proposed to lower the income eligibility threshold from 133% to 100% of the federal poverty line, meaning that beneficiaries with incomes from 101% to 133% of the federal poverty line would lose health coverage. *Id.* at 2057, 2060–61, 2063. Finally, Arkansas Works eliminated a program in which it used Medicaid funds to assist beneficiaries in paying the premiums for employer-provided health care coverage. *Id.* at 2057, 2063, 2073. Arkansas instead used Medicaid premium assistance funds only to help beneficiaries purchase a qualified health plan available on the state Health Insurance Marketplace, requiring all previous recipients of employer-sponsored coverage premiums to transition to coverage offered through the state's Marketplace. *Id.* at 2057, 2063, 2073.

On March 5, 2018, the Secretary approved most of the new Arkansas Works program via a waiver effective until December 31, 2021, but with a few changes. He approved the work requirements but under the label of "community engagement." *Id.* at 2. The Secretary authorized Arkansas to limit retroactive coverage to thirty days before enrollment rather than a complete elimination of retroactive coverage. *Id.* at 3, 12. He also approved Arkansas's decision to terminate the employer-sponsored coverage premium assistance program. *Id.* at 3. The Secretary did not, however, permit Arkansas to limit eligibility to persons making less than or equal to 100% of the federal poverty line. *Id.* at 3 n.1, 11. Instead, the Secretary kept the income eligibility threshold at 133% of the federal poverty line. *Id.* at 3 n.1, 11.

In the approval letter, the Secretary analyzed whether Arkansas Works would "assist in promoting the objectives of Medicaid." *Id.* at 3. The Secretary identified three objectives that he asserted Arkansas Works would promote: "improving health outcomes; . . . address[ing] behavioral and social factors that influence health outcomes; and . . . incentiviz[ing] beneficiaries to engage in their own health care and achieve better health outcomes." *Id.* at 4. In particular, the Secretary stated that Arkansas Works's community engagement requirements would "encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness." *Id.* Further, the Secretary thought the shorter timeframe for retroactive eligibility would "encourage beneficiaries to obtain and maintain health coverage, even when they are healthy," which, in turn, promotes "the ultimate objective of improving beneficiary health." *Id.* at 5. The letter also summarized concerns raised by commenters that the community engagement requirement would "caus[e] disruptions in care" or "create barriers to coverage" for beneficiaries who are not exempt. *Id.* at 6–7. In response, the Secretary noted that Arkansas had several exemptions and would "implement an outreach strategy to inform beneficiaries about how to report compliance." *Id.*

The new work requirements took effect for those aged 30 to 49 on June 1, 2018, and for those aged 20 to 29 on January 1, 2019. *Gresham*, 363 F. Supp. 3d at 172. Charles Gresham along with nine other Arkansans filed an action for declaratory and injunctive relief against the Secretary on August 14, 2018. The district court on March 27, 2019, entered judgment vacating the Secretary's approval, effectively halting

the program. *Gresham*, 363 F. Supp. 3d at 176–85. In its opinion supporting the judgment, the district court relied on *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018) (*Stewart I*), which is the district court's first opinion considering Kentucky's similar demonstration, *Gresham*, 363 F. Supp. 3d at 176. In *Stewart I*, the district court turned to the provision authorizing the appropriations of funds for Medicaid, 42 U.S.C. § 1396-1, and held that, based on the text of that appropriations provision, the objective of Medicaid was to "furnish . . . medical assistance" to people who cannot afford it. *Stewart I*, 313 F. Supp. 3d at 260–61.

With its previously articulated objective of Medicaid in mind, the district court then turned to the Secretary's approval of Arkansas Works. First, the district court noted that the Secretary identified three objectives that Arkansas Works would promote: "(1) 'whether the demonstration as amended was likely to assist in improving health outcomes'; (2) 'whether it would address behavioral and social factors that influence health outcomes'; and (3) 'whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes.'" *Gresham*, 363 F. Supp. 3d at 176 (quoting Ark. AR 4). But "[t]he Secretary's approval letter did not consider whether [Arkansas Works] would reduce Medicaid coverage. Despite acknowledging at several points that commenters had predicted coverage loss, the agency did not engage with that possibility." *Id.* at 177. The district court also explained that the Secretary failed to consider whether Arkansas Works would promote coverage. *Id.* at 179. Instead, the Secretary considered his alternative objectives, primarily healthy outcomes, but the district court observed that "'focus on health is no substitute for considering Medicaid's central concern: covering health costs' through the

provision of free or low-cost health coverage." *Id.* (quoting *Stewart I*, 313 F. Supp. 3d at 266). "In sum," the district court held:

> the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address—despite receiving substantial comments on the matter—whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy.

Id. at 181. The district court entered final judgment on April 4, 2019, and the Secretary filed a notice of appeal on April 10, 2019.

This case was originally a consolidated appeal from the district court's judgment in both the Arkansas and Kentucky cases. The district court twice vacated the Secretary's approval of Kentucky's demonstration for the same failure to address whether Kentucky's program would promote the key objective of Medicaid. *Stewart v. Azar*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019) (*Stewart II*); *Stewart I*, 313 F. Supp. 3d at 274. On December 16, 2019, Kentucky moved to dismiss its appeal as moot because it "terminated the section [1315] demonstration project." Intervenor-Def.-Appellant's Mot. to Voluntarily Dismiss Appeal 1–2 (Dec. 16, 2019), ECF No. 1820334. Neither the government nor the appellees opposed the motion. Gov't's Resp. (Dec. 18, 2019), ECF No. 1820655; Appellees' Resp. (Dec. 20, 2019), ECF No. 1821219.

Although the Secretary has considerable discretion to grant a waiver, we reject the government's contention that such discretion renders his waiver decisions unreviewable. The Administrative Procedure Act's (APA) exception from judicial review for an action

committed to agency discretion is "very narrow," *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 410 (1971); *see also Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2568 (2019), barring judicial review only in those "rare instances" where "there is no law to apply," *Overton Park*, 401 U.S. at 410 (internal quotation marks and citation omitted). The Medicaid statute provides the legal standard we apply here: The Secretary may only approve "experimental, pilot, or demonstration project[s]," and only insofar as they are "likely to assist in promoting the objectives" of Medicaid, 42 U.S.C. § 1315(a). Section 1315 approvals are not among the rare "categories of administrative decisions that courts traditionally have regarded as committed to agency discretion." *Dep't of Commerce*, 139 S. Ct. at 2568.

Additionally, the government asked that we address "the reasoning of the district court's opinion in *Stewart* and the underlying November 2018 HHS approval of the Kentucky demonstration," and second that we vacate the district court's judgment against the federal defendants in the Kentucky case *Stewart II*, 66 F. Supp. 3d 125. Gov't's Resp. 1–2. The appellees opposed both of those additional requests. Appellees' Resp. 1–4. We granted the motion to voluntarily dismiss but declined to vacate the district court's judgment against the federal defendants in *Stewart II*. As to the government's first request, we do not rely on the Secretary's reasoning in the November 2018 approval of Kentucky's demonstration when considering the Secretary's approval of Arkansas's demonstration.

"We review *de novo* the District Court's grant of summary judgment, which means that we review the agency's decision on our own." *Castlewood Prods., L.L.C. v. Norton*, 365 F.3d 1076, 1082 (D.C. Cir. 2004).

Therefore, we will review the Secretary's approval of Arkansas Works in accordance with the Administrative Procedure Act and will set it aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see also C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 181–82 (3d Cir. 1996) (applying the arbitrary and capricious standard of review to a waiver under § 1315); *Beno v. Shalala*, 30 F.3d 1057, 1066–67 (9th Cir. 1994) (same); *Aguayo v. Richardson*, 473 F.2d 1090, 1103–08 (2d Cir. 1973) (same). An agency action that "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise" is arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

II. DISCUSSION

A. Objective of Medicaid

The district court is indisputably correct that the principal objective of Medicaid is providing health care coverage. The Secretary's discretion in approving or denying demonstrations is guided by the statutory directive that the demonstration must be "likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315. While the Medicaid statute does not have a standalone purpose section like some social welfare statutes, *see, e.g.*, 42 U.S.C. § 601(a) (articulating the purposes of the Temporary Assistance for Needy Families program); 42 U.S.C. § 629 (announcing the "objectives" of the Promoting Safe and Stable Families program), it does have a provision that articulates the reasons underlying the appropriations of

funds, 42 U.S.C. § 1396-1. The provision describes the purpose of Medicaid as

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Id. In addition to the appropriations provision, the statute defines "medical assistance" as "payment of part or all of the cost of the following care and services or the care and services themselves." 42 U.S.C. § 1396d(a). Further, as the district court explained, the Affordable Care Act's expansion of health care coverage to a larger group of Americans is consistent with Medicaid's general purpose of furnishing health care coverage. *See Stewart I*, 313 F. Supp. 3d at 260 (citing Pub. L. No. 111-148, 124 Stat. 119, 130, 271 (2010)). The text consistently focuses on providing access to health care coverage.

Both the First and Sixth Circuits relied on Medicaid's appropriations provision quoted above in concluding that "[t]he primary purpose of Medicaid is to enable states to provide medical services to those whose 'income and resources are insufficient to meet the costs of necessary medical services.'" *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (quoting 42 U.S.C. § 1396 (2000)), *aff'd*, 538 U.S. 644 (2003); *Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016). Similarly, the Ninth Circuit relied on both the appropriations provision and the definition of "medical assistance" when describing Medicaid as "a federal grant program that encourages

states to provide certain medical services" and identifying a key element of "medical assistance" as the spending of federally provided funds for medical coverage. *Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034–35 (9th Cir. 2011).

Beyond relying on the text of the statute, other courts have consistently described Medicaid's objective as primarily providing health care coverage. For example, the Third Circuit succinctly stated, "We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it." *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991). Likewise, the Supreme Court characterized Medicaid as a "program . . . [that] provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs." *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006); *see also Virginia ex rel. Hunter Labs., L.L.C. v. Virginia*, 828 F.3d 281, 283 (4th Cir. 2016) (quoting *Ahlborn* in the section of the decision explaining the important aspects of Medicaid).

The statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care. There might be secondary benefits that the government was hoping to incentivize, such as healthier outcomes for beneficiaries or more engagement in their health care, but the "means [Congress] has deemed appropriate" is providing health care coverage. *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 n.4 (1994). In sum, "the intent of Congress is clear" that Medicaid's objective is to provide health care coverage, and, as a result, the Secretary "must give effect to [that] unambiguously

expressed intent of Congress." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984).

Instead of analyzing whether the demonstration would promote the objective of providing coverage, the Secretary identified three alternative objectives: "whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." Ark. AR 4. These three alternative objectives all point to better health outcomes as the objective of Medicaid, but that alternative objective lacks textual support. Indeed, the statute makes no mention of that objective.

While furnishing health care coverage and better health outcomes may be connected goals, the text specifically addresses only coverage. 42 U.S.C. § 1396-1. The Supreme Court and this court have consistently reminded agencies that they are "bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *MCI Telecomms.*, 512 U.S. at 231 n. 4; *see also Waterkeeper All. v. EPA*, 853 F.3d 527, 535 (D.C. Cir. 2017); *Colo. River Indian Tribes v. Nat'l Indian Gaming Comm'n*, 466 F.3d 134, 139–40 (D.C. Cir. 2006). The means that Congress selected to achieve the objectives of Medicaid was to provide health care coverage to populations that otherwise could not afford it.

To an extent, Arkansas and the government characterize the Secretary's approval letter as also identifying transitioning beneficiaries away from governmental benefits through financial independence or

commercial coverage as an objective promoted by Arkansas Works. Ark. Br. 14, 37–42; Gov't Br. 24–25, 32. This argument misrepresents the Secretary's letter. The approval letter has a specific section for the Secretary's determination that the project will assist in promoting the objectives of Medicaid. Ark. AR 3–5. The objectives articulated in that section are the health-outcome goals quoted above. That section does not mention transitioning beneficiaries away from benefits. The district court's discussion of the Secretary's objectives confirms our interpretation of this letter. It identifies the Secretary's alternative objective as "improv[ing] health outcomes." *Gresham*, 363 F. Supp. 3d at 179. There is no reference to commercial coverage in the Secretary's approval letter, and the only reference to beneficiary financial independence is in the section summarizing public comments. In response to concerns about the community engagement requirements creating barriers to coverage, the Secretary stated, "Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence." Ark. AR 6. But "[n]owhere in the Secretary's approval letter does he justify his decision based . . . on a belief that the project will help Medicaid-eligible persons to gain sufficient financial resources to be able to purchase private insurance." *Gresham*, 363 F. Supp. 3d at 180–81. We will not accept post hoc rationalizations for the Secretary's decision. *See State Farm*, 463 U.S. at 50.

Nor could the Secretary have rested his decision on the objective of transitioning beneficiaries away from government benefits through either financial independence or commercial coverage. When Congress

wants to pursue additional objectives within a social welfare program, it says so in the text. For example, the purpose section of TANF explicitly includes "end[ing] the dependence of needy parents on government benefits by promoting job preparation, work, and marriage" among the objectives of the statute. 42 U.S.C. § 601(a)(2). Also, both TANF and the Supplemental Nutrition Assistance Program (SNAP) condition eligibility for benefits upon completing a certain number of hours of work per week to support the objective of "end[ing] dependence of needy parents on government benefits." 42 U.S.C. §§ 601(a)(2), 607(c) (TANF); 7 U.S.C. § 2015(d)(1) (SNAP). In contrast, Congress has not conditioned the receipt of Medicaid benefits on fulfilling work requirements or taking steps to end receipt of governmental benefits.

The reference to independence in the appropriations provision and the cross reference to TANF cannot support the Secretary's alternative objective either. The reference to "independence" in the appropriations provision is in the context of assisting beneficiaries in achieving functional independence through rehabilitative and other services, not financial independence from government welfare programs. 42 U.S.C. § 1396-1. Medicaid also grants states the "[o]ption" to terminate Medicaid benefits when a beneficiary who receives both Medicaid and TANF fails to comply with TANF's work requirements. *See* 42 U.S.C. § 1396u-1(b)(3)(A). The provision gives states, therefore, the ability to coordinate benefits for recipients receiving both TANF and Medicaid. It does not go so far as to incorporate TANF work requirements and additional objectives into Medicaid.

Further, the history of Congress's amendments to social welfare programs supports the conclusion that

Congress did not intend 42 U.S.C. § 1396u-1(b)(3)(A) to incorporate TANF's objectives and work requirements into Medicaid. In 1996, SNAP already included work requirements to maintain eligibility. 7 U.S.C. § 2015(d)(1) (1994). Also in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act, which replaced Aid to Families with Dependent Children with TANF and added work requirements. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, sec. 103, § 407, 110 Stat. 2105, 2129–34. At the same time, it added 42 U.S.C. § 1396u-1(b)(3)(A) to Medicaid. *Id.* at sec. 114, § 1931, 110 Stat. at 2177–80. The fact that Congress did not similarly amend Medicaid to add a work requirement for all recipients—at a time when the other two major welfare programs had those requirements and Congress was in the process of amending welfare statutes—demonstrates that Congress did not intend to incorporate work requirements into Medicaid through § 1396u-1(b)(3)(A).

In short, we agree with the district court that the alternative objectives of better health outcomes and beneficiary independence are not consistent with Medicaid. The text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage.

B. The Approvals Were Arbitrary and Capricious

With the objective of Medicaid defined, we turn to the Secretary's analysis and approval of Arkansas's demonstration, and we find it wanting. In order to survive arbitrary and capricious review, agencies need to address "important aspect[s] of the problem." *State*

Farm, 463 U.S. at 43. In this situation, the loss of coverage for beneficiaries is an important aspect of the demonstration approval because coverage is a principal objective of Medicaid and because commenters raised concerns about the loss of coverage. *See*, *e.g.*, Ark. AR 1269–70, 1277–78, 1285, 1294–95.

A critical issue in this case is the Secretary's failure to account for loss of coverage, which is a matter of importance under the statute. The record shows that the Arkansas Works amendments resulted in significant coverage loss. In Arkansas, more than 18,000 people (about 25% of those subject to the work requirement) lost coverage as a result of the project in just five months. Ark. Dep't of Human Servs., Arkansas Works Program 8 (Dec. 2018), https://humanservices.arkansas.gov/images/uploads/011519AWReport.pdf. Additionally, commenters on the Arkansas Works amendments detailed the potential for substantial coverage loss supported by research evidence. Ark. AR 1269–70, 1277–78, 1285, 1294–95, 1297, 1307–08, 1320, 1326, 1337–38, 1341, 1364–65, 1402, 1421. The Secretary's analysis considered only whether the demonstrations would increase healthy outcomes and promote engagement with the beneficiary's health care. *Id.* at 3–5. The Secretary noted that some commenters were concerned that "these requirements would be burdensome on families or create barriers to coverage." *Id.* at 6. But he explained that Arkansas would have "outreach and education on how to comply with the new community engagement requirements" and that Centers for Medicare and Medicaid Services could discontinue the program if data showed that it was no longer in the public interest. *Id.* The Secretary also concluded that the "overall health benefits to the [a]ffected population . . . outweigh the health-risks with respect to those who fail to" comply with the new

requirements. *Id.* at 7. While Arkansas did not have its own estimate of potential coverage loss, the estimates and concerns raised in the comments were enough to alert the Secretary that coverage loss was an important aspect of the problem. Failure to consider whether the project will result in coverage loss is arbitrary and capricious.

In total, the Secretary's analysis of the substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences. Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking. *See, e.g., Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017) (critiquing an agency for "brush[ing] aside critical facts" and not "adequately analyz[ing]" the consequences of a decision); *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (analyzing whether an agency actually considered a concern rather than merely stating that it considered the concern).

True, the Secretary's approval letter is not devoid of analysis. It does contain the Secretary's articulation of how he thought the demonstrations would assist in promoting an entirely different set of objectives than the one we hold is the principal objective of Medicaid. In some circumstances it may be enough for the agency to assess at least one of several possible objectives. *See Fresno Mobile Radio, Inc. v. FCC*, 165 F.3d 965, 971 (D.C. Cir. 1999). But in such cases, the statute lists several objectives, some of which might lead to conflicting decisions. *Id.*; *see also Melcher v. FCC*, 134 F.3d 1143, 1154 (D.C. Cir. 1998). For example, in both *Fresno Mobile Radio* and *Melcher*, the statute at issue included five separate objectives for FCC to consider

when creating auctions for licenses, including "the development and rapid deployment of new technologies," "promoting economic opportunity and competition," and the "efficient and intensive use of the electromagnetic spectrum." 47 U.S.C. § 309(j)(3). In *Fresno Mobile Radio*, we recognized that these objectives could point to conflicting courses of action, so the agency could give precedence to one or several objectives over others without acting in an arbitrary or capricious manner. *Fresno Mobile Radio*, 165 F.3d at 971; *see also Melcher*, 134 F.3d at 1154; *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1101–03 (D.C. Cir. 2009) (explaining that an agency may not "depart from" statutory principles "altogether to achieve some other goal"). The crucial difference in this case is that the Medicaid statute identifies its primary purpose rather than a laundry list. The primary purpose is

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

42 U.S.C. § 1396-1. Importantly, the Secretary disregarded this statutory purpose in his analysis. While we have held that it is not arbitrary or capricious to prioritize one statutorily identified objective over another, it is an entirely different matter to prioritize non-statutory objectives to the exclusion of the statutory purpose.

III. CONCLUSION

Because the Secretary's approval of Arkansas Works was arbitrary and capricious, we affirm the district court's judgment vacating the Secretary's approval.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 18-1900 (JEB)

CHARLES GRESHAM, *et al.*,

Plaintiffs,

v.

ALEX M. AZAR II, *et al.*,

Defendants.

MEMORANDUM OPINION

Adrian McGonigal is 40 years old and lives with his brother in Pea Ridge, Arkansas. He used to have a job working in the shipping department of Southwest Poultry, a food-service company located nearby, although he received no medical insurance through his employer. Like many Americans, he has several serious medical conditions. Beginning in 2014, McGonigal was able to receive medical care — including regular doctor visits and numerous prescription drugs — through the state's expanded Medicaid program. In mid-2018, however, McGonigal learned that he would be subject to new work requirements, which he would have to report online, as a condition of receiving health benefits. These were imposed by the Arkansas Works Amendments (AWA), approved by the U.S. Secretary of Health and Human Services in March 2018. Despite his lack of access to, and difficulty working with, computers, he was able to report his employment in June 2018, but he did not

know he needed to continue to do so each month. As a result, when he went to pick up his prescriptions in October, the pharmacist told him that he was no longer covered, and his medicines would cost him $800. In the absence of Medicaid, he could not afford the cost of the prescriptions and so did not pick them up. His health conditions then flared up, causing him to miss several days of work, and Southwest Poultry fired him for his absences. He thus lost his Medicaid coverage and his job.

Anna Book is 38 years old and lives in Little Rock. She currently rents a room in an apartment but was homeless for most of the last eight years. In July 2018, she got a job as a dishwasher in a restaurant, for which she works about 24 hours each week. Before that, she was unemployed for two years. She nevertheless also had health care provided through Arkansas's Medicaid program, which a local pastor helped her sign up for in 2014. Book learned last August that, pursuant to AWA, she would have to report 80 hours each month of employment or other activities to keep that coverage. While she reported her compliance in August and September with the pastor's help — she does not have reliable internet access — Book has several health conditions and worries that she will not maintain sufficient hours at her job to keep her coverage.

Russell Cook is 26 and also lives in Little Rock. He is currently homeless. While he has spent time working as a landscaper, he is not presently employed and has minimal job prospects. The state's Medicaid program has previously given him access to health care for various health conditions, including a torn Achilles tendon and serious dental problems. Cook, however, does not believe he will be able to comply

with the new AWA work requirements, which began applying to him in January 2019. Lacking access to the internet or a phone, he also worries that he will be unable to report compliance with those requirements. He thus expects to lose his Medicaid coverage.

These are three of the ten Arkansans who come to this Court seeking to undo the work requirements the state added in 2018 to its Medicaid program. They sued the Secretary of Health and Human Services in August 2018, arguing that the federal government's approval of the state's new requirements violated the Administrative Procedure Act and the Constitution.

Plaintiffs' suit does not offer an issue of first impression. Indeed, this Court just last summer considered a challenge to the Secretary's approval of very similar changes to Kentucky's Medicaid program — including work or "community engagement" requirements — in *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018) *(Stewart* I). There, it vacated the agency's decision because it had not adequately considered whether the program "would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Id.* at 243. Plaintiffs point to the identical deficiency in the record in this case. Despite the protestations in its (and intervenor Arkansas's) briefing, HHS conceded at oral argument that the administrative decision in this case shares the same problem as the one in *Stewart I*. *See* Oral Argument Transcript at 6–7. The Court's job is thus easy in one respect: the Secretary's approval cannot stand.

Yet a separate question remains: what is the proper remedy? In *Stewart I*, the Court vacated the approval and remanded to the Secretary. Here, however, the Government argues that vacatur is improper both because, unlike Kentucky, AWA is already active and

halting it would be quite disruptive, and because any error is easily fixed, just as it has been for Kentucky. The challengers disagree, positing that the deficiency in the approval is substantial and that any resulting disruption is outweighed by the ongoing harms suffered by the more than 16,000 Arkansans who have lost their Medicaid coverage. Given the seriousness of the deficiencies — which, as this Court explains in a separate Opinion issued today, the remand in Kentucky did *not* cure — and the absence of lasting harms to the Government relative to the significant ones suffered by Arkansans like Plaintiffs, the Court will vacate the Secretary's approval and remand for further proceedings.

I. BACKGROUND

As it did in *Stewart I*, the Court begins with an overview of the relevant history and provisions of the Medicaid Act. *See* 313 F. Supp 3d. at 243–44. It then turns to Arkansas's challenged plan before concluding with the procedural history of this case.

A. Legal Background

1. *The Medicaid Act*

Since 1965, the federal government and the states have worked together to provide medical assistance to certain vulnerable populations under Title XIX of the Social Security Act, commonly known as Medicaid. *See* 42 U.S.C. § 1396-1. The Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services, has primary responsibility for overseeing Medicaid programs. Under the cooperative federal-state arrangement, participating states submit their "plans for medical assistance" to the Secretary of HHS. *Id.* To

receive federal funding, those plans — along with any material changes to them — must be "approved by the Secretary." *Id.; see also* 42 C.F.R. § 430.12(c). Currently, all states have chosen to participate in the program.

To be approved, state plans must comply with certain minimum parameters set out in the Medicaid Act. *See* 42 U.S.C. § 1396a (listing 83 separate requirements). One such provision requires state plans to "mak[e] medical assistance available" to certain low-income individuals. *Id.* § 1396a(a)(10)(A). Until recently, that group included pregnant women, children, and their families; some foster children; the elderly; and people with certain disabilities. *Id.* In 2010, however, Congress enacted the Patient Protection and Affordable Care Act (ACA), colloquially known as Obamacare, "to increase the number of Americans covered by health insurance." *Nat'l Fed. of Indep. Business v. Sebelius*, 567 U.S. 519, 538 (2012). Under that statute, states can expand their Medicaid coverage to include additional low-income adults under 65 who would not otherwise qualify. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

Generally, a state must cover all qualified individuals or forfeit its federal Medicaid funding. *Id.* § 1396a(a)(10)(B). That was originally so for the ACA expansion population as well. *See* 42 U.S.C. § 1396c. In *NFIB*, however, the Supreme Court held that Congress could not, consistent with the Spending Clause of the Constitution, condition previously appropriated Medicaid funds on the state's agreeing to the expansion. *See* 567 U.S. at 584–85. The result was that states could choose *not* to cover the new population and lose no more than the funds that would have been appropriated for that group. *Id.* at 587. If, however, the

state decided to provide coverage, those individuals would become part of its mandatory population. *Id.* at 585–87 (explaining that Congress may "offer[] funds under the Affordable Care Act to expand the availability of health care, and requir[e] that States accepting such funds comply with the conditions on their use"). In that instance, the state must afford the expansion group "full benefits" — *i.e.*, it must provide "medical assistance for all services covered under the State plan" that are substantially equivalent "in amount, duration, or scope . . . to the medical assistance available for [other] individual[s]" covered under the Act. *See* 42 U.S.C. § 1396d(y)(2)(B); 42 C.F.R. § 433.204(a)(2).

The Medicaid Act, in addition to defining *who* is entitled to coverage, also ensures *what* coverage those enrolled individuals receive. Under § 1396a, states must cover certain basic medical services, *see* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), and the statute limits the amount and type of premiums, deductions, or other cost-sharing charges that a state can impose on such care. *Id.* § 1396a(a)(14); *see also id.* § 1396*o*. Other provisions require states to provide three months of retroactive coverage once a beneficiary enrolls, *see id.* § 1396a(a)(34), and to ensure that recipients receive all "necessary transportation . . . to and from providers." 42 C.F.R. § 431.53. Finally, states must "provide such safeguards as may be necessary to assure" that eligibility and services "will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

2. *Section 1115 of Social Security Act*

Both before and after the passage of the ACA, a state is not entirely locked in; instead, if it wishes to deviate from the Medicaid Act's requirements, it can seek a

waiver from the Secretary of HHS. *See* 42 U.S.C. § 1315. In enacting the Social Security Act (and, later, the Medicaid program within the same title), Congress recognized that statutory requirements "often stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 1589, 87th Cong., 2d Sess. 19, *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961–62. To that end, § 1115 of the Social Security Act allows the Secretary to approve "experimental, pilot, or demonstration project[s]" in state medical plans that would otherwise fall outside Medicaid's parameters. The Secretary can approve only those projects that "in [his] judgment . . . [are] likely to assist in promoting the [Act's] objectives." 42 U.S.C. § 1315(a). As conceived, demonstration projects were "expected to be selectively approved by the Department and to be those which are designed to improve the techniques of administering assistance." *Supra* S. Rep. No. 1589 at 1962. Once the Secretary has greenlighted such a project, he can then waive compliance with the requirements of § 1396a "to the extent and for the period . . . necessary to enable [the] State . . . to carry out such project." *Id.* § 1315(a)(1).

While the ultimate decision whether to grant § 1115 approval rests with the Secretary, his discretion is not boundless. Before HHS can act on a waiver application, the state "must provide at least a 30-day public notice[-]and[-]comment period" regarding the proposed program and hold at least two hearings at least 20 days before submitting the application. *See* 42 C.F.R. §§ 431.408(a)(1), (3). Once a state completes those prerequisites, it then sends an application to CMS. *Id.* § 431.412 (listing application requirements). After the agency notifies the state that it has received the waiver application, a federal 30-day public-notice

period commences, and the agency must wait at least 45 days before rendering a final decision. *Id.* §§ 431.416(b), (e)(1).

B. Factual Background

1. *Arkansas Works Amendments*

Arkansas's Medicaid program dates back to 1970. For most of the program's history, the state maintained among the most stringent eligibility thresholds in the nation for adults, covering only the aged, disabled, and parents with very low incomes. *See* ECF 53-6, Exh. 54 (Ark. Health Care Independence Program Interim Report) at 16. That changed with the passage of the ACA. While states had a choice after *NFIB* not to expand Medicaid, Arkansas was one of those that opted to do so. Under its expansion program, which began January 1, 2014, Medicaid-eligible persons were given the opportunity to enroll in private insurance plans financed by the state. *See* AR 71. In its first two years, the program provided health coverage to more than 278,000 newly eligible individuals, helping to lower the uninsured rate from 19% to 11%. *See* AR 1274. The program became known as Arkansas Works in January 2017.

That month featured another significant change in the political landscape, as the Trump administration took over from President Obama. In March 2017, then-Secretary Thomas Price and CMS Director Seema Verma sent a letter to all 50 governors announcing the administration's view that the ACA's expansion of Medicaid was "a clear departure from the core, historical mission of the program." *See* AR 85. They thus alerted states of the agency's "intent to use existing Section 1115 demonstration authority" to help revamp Medicaid. *See* AR 86. Together they promised to find

"a solution that best uses taxpayer dollars to serve" those individuals they deemed "truly vulnerable." *Id.* Heeding HHS's call, Governor Asa Hutchinson proposed three substantial amendments to Arkansas Works under Section 1115. *See* AR 2057. First, he proposed to shift income eligibility for the expansion population from 133% to 100% of the Federal Poverty Line. *Id.* Second, he proposed to "institute work requirements as a condition" of continued Medicaid coverage. *Id.* Third, he proposed to eliminate retroactive health coverage. *Id.* The state did not estimate the effects these amendments would have on Medicaid coverage. CMS held a public-comment period from July 11 to August 10, 2017, and numerous organizations offered their views and analysis of the changes.

On March 5, 2018, the Secretary approved the work requirements and limits to retroactive coverage, concluding that they were "likely to assist in improving health outcomes" and "incentivize beneficiaries to engage in their own health care." AR 2–4. Under the new work requirements, most able-bodied adults in the Medicaid expansion population ages 19 to 49 must complete each month 80 hours of employment or other qualifying activities — or earn income equivalent to 80 hours of work. *Id.* Compliance was required to be reported monthly through an online portal. *See* AR 29. Various groups of persons are exempt, including the medically frail, pregnant women, full-time students, and persons in drug- or alcohol-treatment programs. *See* AR 28. Nonexempt individuals who do not report sufficient qualifying hours for any three months in a plan year are disenrolled from Medicaid for the remainder of that year and not permitted to re-enroll until the following plan year. *See* AR 14, 30–31. The work requirements took effect for persons age 30 to 49 on June 1, 2018, and for persons age 20 to 29 on

January 1, 2019. *See* ECF No. 26-3 (Arkansas Works Eligibility and Enrollment Monitoring Plan) at 7–8. As to retroactive coverage, the Secretary approved a reduction from the three months required by the Act to one month; the more drastic proposal of eliminating such coverage entirely was abandoned, as was the Governor's request to reduce eligibility down to 100% of the FPL. *See* AR 12, 22.

According to Arkansas's Department of Human Services, only a small percentage of the persons required to report compliance with the work requirements actually did so during the first six months of the program. In October, for example, only 12.3% (1687 out of 13653) of persons not exempt from the requirements reported any kind of qualifying activity. *See* ECF No. 42-1 (Arkansas Works Reports June–November 2018) at 47, 52. Since the program began, more than 16,900 individuals have lost Medicaid coverage for some period of time for not reporting their compliance. *Id.* at 18, 27, 36, 45. It is not known what percentage of these individuals completed the work requirements but did not report versus those who did not engage in the work itself.

2. *Kentucky HEALTH*

Arkansas was not the only state interested in the new administration's proposal to rethink the Medicaid Expansion. The Commonwealth of Kentucky proposed a demonstration project — called Kentucky HEALTH — with similar community-engagement requirements and cutbacks to retroactive coverage. (It also contained other elements not relevant here.) Kentucky, unlike Arkansas, did estimate the coverage effects of its project, explaining that thousands of persons would lose their Medicaid benefits over the course of the project; indeed, their estimate corre-

sponded to about 95,000 persons losing Medicaid for one full year. As it did in Arkansas, the Secretary approved that project on the ground that it was likely to "improv[e] health outcomes" and "increas[e] individual engagement in health care decisions." *Stewart I*, 313 F. Supp. 3d at 258 (quoting AR 7).

Before the project took effect, several Medicaid recipients challenged the Secretary's approval in this Court. They argued, among other things, that the agency had failed to adequately explain why Kentucky HEALTH promoted the objectives of Medicaid and that approval of the project exceeded HHS's statutory authority. The Court concluded that the plaintiffs were right in one central and dispositive respect: "[T]he Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." *Id.* at 243. It therefore vacated the Secretary's approval and remanded the matter to the agency for further consideration. *Id.* at 273.

HHS has since reopened the comment period and subsequently reapproved Kentucky's project, offering additional explanation for why the project advances the objectives of the Medicaid Act. The parties have now come back to the Court and filed cross-motions for summary judgment in that case. The Court issues a separate Opinion today resolving those motions, which it will refer to as *Stewart II*.

C. Procedural History

Several Arkansas residents filed this lawsuit in August 2018. They assert that the Secretary's approval of the Arkansas Works Amendments was arbitrary and capricious, in excess of his statutory authority, and in violation of the Take Care Clause of

the Constitution. Because it was designated as related to *Stewart I*, *see* ECF No. 2, the case was directed to this Court. While Defendants objected to the related-case designation, *see* ECF No. 17, the Court determined that the cases' common legal and factual issues militated in favor of its retaining the matter. *See* Minute Order of Sept. 12, 2018. The State of Arkansas has since intervened as a Defendant, and numerous amici have also joined the fray. Dueling Cross-Motions for Summary Judgment are now ripe.

II. LEGAL STANDARD

The parties have cross-moved for summary judgment on the administrative record. The summary-judgment standard set forth in Federal Rule of Civil Procedure 56(c), therefore, "does not apply because of the limited role of a court in reviewing the administrative record." *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 89 (D.D.C. 2006); *see also Bloch v. Powell*, 227 F. Supp. 2d 25, 30 (D.D.C. 2002), *aff'd*, 348 F.3d 1060 (D.C. Cir. 2003). "[T]he function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did." *Sierra Club*, 459 F. Supp. 2d. at 90 (quotation marks and citation omitted). "Summary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [Administrative Procedure Act] standard of review." *Loma Linda Univ. Med. Ctr. v. Sebelius*, 684 F. Supp. 2d 42, 52 (D.D.C. 2010) (citation omitted).

The Administrative Procedure Act "sets forth the full extent of judicial authority to review executive agency action for procedural correctness." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513 (2009). It

requires courts to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2). Agency action is arbitrary and capricious if, for example, the agency "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

In other words, an agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id.* at 43 (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)) (internal quotation marks omitted). Courts, accordingly, "do not defer to the agency's conclusory or unsupported suppositions," *United Techs. Corp. v. Dep't of Def.*, 601 F.3d 557, 562 (D.C. Cir. 2010) (quoting *McDonnell Douglas Corp. v. Dep't of the Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004)), and "agency 'litigating positions' are not entitled to deference when they are merely [agency] counsel's '*post hoc* rationalizations' for agency action, advanced for the first time in the reviewing court." *Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 156 (1991) (citation omitted). Although a reviewing court "may not supply a reasoned basis for the agency's action that the agency itself has not given," a decision that is not fully explained may, nevertheless, be upheld "if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc.*, 419 U.S. 281, 285-86 (1974) (citation omitted).

III. ANALYSIS

The Court, as it must, first addresses whether there is subject-matter jurisdiction before proceeding to the merits of Plaintiffs' challenges.

A. Jurisdiction

Unlike in *Stewart I*, Defendants do not contest Plaintiffs' standing to challenge the Secretary's approval of the Arkansas Works Amendments as a whole. The Court, nevertheless, has an independent duty to assure that it has subject-matter jurisdiction in this case. *See Kaplan v. Cent. Bank of Islamic Repub. of Iran*, 896 F.3d 501, 509 (D.C. Cir. 2018). To establish standing under Article III, Plaintiffs must show that they have suffered a concrete injury that is fairly traceable to the challenged conduct and that is likely to be redressed by a favorable judicial decision. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 590 (1992). On review, the Court easily concludes that at least one Plaintiff has established all three elements. Consider, for example, Adrian McGonigal, whom we encountered in this Opinion's opening paragraph. He attests that he has lost his Medicaid coverage as a result of the community-engagement requirement and has thus been unable to pay for certain medical bills and prescription drugs. *See* ECF No. 27-3 (McGonigal Declaration). Or look to Russell Cook, also mentioned in the introduction, who avers that he will be unable to meet the community-engagement requirement once it applies to him and thus believes that loss of his health-care coverage is imminent. *See* ECF No. 27-7 (Cook Declaration). From these declarations and others submitted with Plaintiffs' Motion, there is little doubt that at least one Plaintiff has suffered an injury (or will suffer an injury in the future) — the loss of Medicaid coverage — that is attributable to the

Secretary's approval of AWA, and that a favorable decision from the Court would redress it. *See NB ex rel. Peacock v. District of Columbia*, 682 F.3d 77, 82–83 (D.C. Cir. 2012).

While standing is thus easily established for their claim challenging the project as a whole, the state of Arkansas attacks Plaintiffs' standing to make one of their arguments. It specifically says that no Plaintiff may challenge Arkansas Works' online-only reporting requirements because the state changed its policy before this suit so as to allow reporting by phone or in person. *See* ECF No. 39 (Arkansas MSJ) at 34. There is no need for the Court to weigh in here. Because it resolves this case based on the challenge to the Arkansas Works Amendments writ large, the Court declines to decide whether certain Plaintiffs have standing to challenge this particular part of the project.

B. Merits

With that threshold issue easily dispatched, the Court turns to the merits. Plaintiffs' central position is identical to that of the challengers in *Stewart I:* the Arkansas Works Amendments "fundamentally alter the design and purpose of Medicaid." ECF No. 27 (MSJ) at 13. They thus assail the Secretary's approval of the Amendments on similar fronts. First, with regard to the project as a whole, Plaintiffs assert that HHS did not sufficiently consider whether it would promote the objectives of Medicaid, including how it would affect the provision of medical assistance to the needy. Second, they maintain that the Secretary lacked statutory authority to approve numerous aspects of AWA. Finally, Plaintiffs posit that a letter CMS issued in January 2018 violates the APA because it did not go through notice and comment. As in

Stewart I, the Court only needs to consider the first of these contentions: "whether the Secretary acted arbitrarily or capriciously in concluding that [Arkansas Works] was 'likely to assist in promoting the objectives' of the Medicaid Act." *Stewart I*, 313 F. Supp. 3d at 259 (quoting 42 U.S.C. § 1315(a)).

Under that deferential standard, the Court "is not empowered to substitute its judgment for that of the agency." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). Nor can it "presume even to comment upon the wisdom of [Arkansas's] effort at [Medicaid] reform." *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 181 (3d Cir. 1996). Still, it is a fundamental principle of administrative law that "agencies are required to engage in reasoned decisionmaking." *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015) (internal quotation marks omitted). This means that an agency must "examine all relevant factors and record evidence." *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017). At minimum, the Secretary cannot "entirely fail[] to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Rather, he must "adequately analyze . . . the consequences" of his actions. *See Am. Wild Horse*, 873 F.3d at 932. In doing so, "[s]tating that a factor was considered . . . is not a substitute for considering it." *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986). The agency must instead provide more than "conclusory statements" to prove it "consider[ed] [the relevant] priorities." *Id.* at 1057.

With that framework in mind, Plaintiffs' position is simple: "The purpose of [] Medicaid" is to enable states "to furnish health care coverage to people who cannot

otherwise afford it." MSJ at 1, 15. Yet the Secretary, just as in *Stewart I*, "failed to consider adequately" the impact of the proposed project on Medicaid coverage. *See Am. Wild Horse*, 873 F.3d at 923. Indeed, he neither offered his own estimates of coverage loss nor grappled with comments in the administrative record projecting that the Amendments would lead a substantial number of Arkansas residents to be disenrolled from Medicaid. Those omissions, they urge, make his decision arbitrary and capricious.

Plaintiffs are correct. As Opening Day arrives, the Court finds its guiding principle in Yogi Berra's aphorism, "It's *déjà vu* all over again." In other words, as the Secretary's failures here are nearly identical to those in *Stewart I*, the Court's analysis proceeds in the same fashion. It begins with the basic deficiencies in the Secretary's approval in this case and then examines Defendants' counterarguments.

1. *The Secretary's Consideration of Medicaid's Objectives*

Before approving a demonstration or pilot project, the Secretary must identify the objectives of Medicaid and explain why the project is likely to promote them. As it did in *Stewart I*, the Court assumes that the Secretary's identification of those objectives is entitled to *Chevron* deference. That is, in reviewing his interpretation, the Court must first ask whether "Congress has directly spoken to the precise question at issue," and, if not, whether "the agency's answer is based on a permissible construction of the statute." *Chevron U.S.A., Inc. v. Nat'l Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984). According such deference is not of much practical significance here, however, because the Secretary agrees with the Court's under-

standing of a "core objective" of the Medicaid Act. *See* ECF No. 52 (HHS Reply) at 5.

In *Stewart I*, the Court explained that "one of Medicaid's central objectives" is to "furnish medical assistance" to persons who cannot afford it. *See* 313 F. Supp. 3d at 243, 261, 266, 273. That conclusion followed ineluctably from § 1396-1 of the Act, which provides that Congress appropriated Medicaid funds "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance . . . [to] individuals[] whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Case law discussing the program's objectives confirms as much. *See*, *e.g.*, *Schweiker v. Hogan*, 453 U.S. 569, 571 (1982) (explaining that Congress established Medicaid "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons"); *W. Va. Univ. Hosps. Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989) ("[T]he primary purpose of [M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it.").

Defendants, as mentioned, agree that providing health coverage to the needy is a purpose of the Act. *See* ECF No. 37 (HHS MSJ) at 12; Ark. MSJ at 13. In Arkansas's words, "[T]hat Medicaid coverage is a Medicaid objective is readily apparent from the substantive provisions of the statute." Ark. MSJ at 13. The Secretary, in fact, refers to the provision of medical care to eligible persons as "Medicaid's *core* objective." HHS Reply at 5 (emphasis added). HHS

nevertheless did not consider whether AWA would advance or impede that objective.

In his approval letter, the Secretary explained that he considered the following objectives of the Medicaid Act: (1) "whether the demonstration as amended was likely to assist in improving health outcomes"; (2) "whether it would address behavioral and social factors that influence health outcomes"; and (3) "whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes." AR 4. Those are substantially the same objectives HHS considered when it first approved the Kentucky program. *See Stewart I*, 313 F. Supp. 3d at 261–62. What the Court said in that case thus holds true here: "While those may be worthy goals, there [i]s a notable omission from the list" — namely, whether the project would "help or hurt [Arkansas] in 'funding . . . medical services for the needy.'" *Id.* (quoting *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985)). By his own description, the Secretary "entirely failed to consider" this question. *See State Farm*, 463 U.S. at 43.

The Government conceded as much at oral argument, stating that HHS's Arkansas approval letter no more addresses the program's effects on Medicaid coverage than the Kentucky approval letter before the Court in *Stewart I*. *See* Tr. at 6–7. Because this is a separate administrative decision on review in a separate case, however, a brief assessment of the deficiency is instructive. To "adequately analyze" the issue of coverage, *Am. Wild Horse*, 873 F.3d at 932, the Secretary needed to consider whether the demonstration project would be likely to cause recipients to *lose* coverage and whether it would cause others to *gain* coverage. He did neither.

a. *Risk to Coverage*

The Secretary's approval letter did not consider whether AWA would *reduce* Medicaid coverage. Despite acknowledging at several points that commenters had predicted coverage loss, the agency did not engage with that possibility. For example, after mentioning that commenters had "expressed concerns that these requirements would . . . create barriers to coverage," the Secretary responded that "[t]he state has pledged to do beneficiary outreach and education on how to comply" and has created an "easy" online reporting system. *See* AR 6. He also pointed to exemptions built into the project and to Arkansas's assurances that it will allow for "reasonable modifications" for beneficiaries unable to meet the requirements. *Id.* But those statements did not grapple with the coverage issue. Not only did they fail to address whether coverage loss would occur as predicted, but they also ignored that commenters had projected that such loss would happen regardless of the exemptions and the education and reporting processes; indeed, some comments pinpointed online-only reporting as a *source* of coverage loss. *See*, *e.g.*, AR 1272, 1287.

Later, HHS noted again many commenters' view that community-engagement requirements would "create barriers to coverage for non-exempt people who might have trouble accessing care." AR 6. Instead of addressing that issue, however, it merely said: "We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment." *Id.* That position says nothing about the risk of coverage loss those requirements create. The bottom line: the Secretary did no more than acknowledge — in a conclusory manner, no less — that commenters forecast a loss in Medicaid coverage. But

"[s]tating that a factor was considered . . . is not a substitute for considering it." *Getty*, 805 F.2d at 1055. His decision thus falls short of the kind of "reasoned decisionmaking" the APA requires. *See Michigan*, 135 S. Ct. at 2706.

Defendants argue that the Secretary did not need to — and perhaps was not even able to — provide a numeric estimate of coverage loss. *See* HHS MSJ at 21; Ark. MSJ at 24. While producing an empirical prediction of coverage loss does not seem like too much to ask of the expert agency tasked with supervising Medicaid programs in all 50 states, the Court does not need to decide whether such an estimate is required. Here, numerous commenters predicted that substantial coverage loss would occur; a table cataloguing the relevant comments is included at the end of this Opinion in an Appendix. *See*, *e.g.*, AR 1269 (Arkansas Advocates noting that requirement "will increase the rate of uninsured Arkansans"); AR 1277 (American Congress Obstetricians and Gynecologists explaining that "[t]he experience of the TANF program . . . demonstrates that imposing work requirements on Medicaid beneficiaries would . . . lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment."); *see also* ECF No. 33 (Amicus Brief of Deans, Chairs, and Scholars) at 14. Under these circumstances, the agency must grapple with the risk of coverage loss. *See Nat'l Lifeline Assoc. v. FCC*, 915 F.3d 19, 30-31 (D.C. Cir. 2019).

The Secretary should explain, for example, whether it agrees with the commenters' coverage predictions. If so, it might elucidate whether it expects the loss to be minor or substantial, and how that weighs against the advancement of other Medicaid objectives. Nothing

close to this appears in the Secretary's approval letter. That does not mean that the Government must "recit[e] and refut[e] every objection submitted in opposition to the proposed demonstration." HHS MSJ at 22. It just means that, at a minimum, the agency cannot "entirely fail[] to consider an important aspect of the problem," repeatedly raised in the comment period. *See State Farm*, 463 U.S. at 43.

Arkansas maintains that the Secretary did not need to consider any reduction in coverage because it — unlike Kentucky — did not predict that the project would even cause coverage loss. *See* Ark. MSJ at 24. But the state's failure in that respect does not alter HHS's inquiry. Under the Medicaid Act, the Secretary may approve only those demonstration projects that are "likely to assist in promoting the objectives of [Medicaid]," and the parties agree that the provision of health coverage is a "central" objective of the Act. *See* 42 U.S.C. § 1315(a); HHS MSJ at 12–13; Ark. MSJ at 13. Whether a state gives the Secretary excellent data or no data at all about coverage, his duty remains the same: to determine whether the proposed project will promote the objectives of the Act, including whether it advances or hinders the provision of health coverage to the needy. If it were otherwise, HHS could approve a project that would decimate Medicaid coverage without so much as addressing the issue where the state did not submit its own estimate of coverage loss. Even putting to one side the agency's affirmative obligation to address coverage loss, however, the Secretary unquestionably has a duty to consider that issue where multiple commenters provide credible forecasts that it will occur. *See*, *e.g.*, AR 1269, 1277, 1285, 1294–95. Here, as has been said, the agency had and neglected that duty.

In a last attempt to resist this conclusion, the Secretary says that he did not need to consider coverage because he had no obligation to offer *any* explanation of his decision to approve a demonstration project. *See* HHS MSJ at 22–23; *see also* Tr. at 9. For support, HHS points to the regulations governing its approval of demonstration projects, which do not explicitly require the Secretary to respond to comments or articulate the basis for his decision. *See* HHS MSJ at 22 (discussing 42 C.F.R. § 431.416). The APA, however, requires more. Where an agency decision is judicially reviewable, as the Court has already held this one is, *see Stewart I*, 313 F. Supp. 3d at 254–56, the Government "must give a reason that a court can measure . . . against the 'arbitrary or capricious' standard of the APA." *Kreis v. Sec'y of Air Force*, 866 F.2d 1508, 1514–15 (D.C. Cir. 1989); *see also Coburn v. McHugh*, 679 F.3d 924, 934 (D.C. Cir. 2012) ("At the very least, the Board must 'provide an explanation that will enable the court to evaluate the agency's rationale at the time of decision.'") (quoting *Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 654 (1990)). HHS's regulations — which require CMS to maintain and publish an administrative record of public comments, any CMS responses, and a written approval or disapproval letter — are fully consonant with this axiomatic administrative-law requirement. *See* 42 C.F.R. § 431.416(f). The argument that no explanation for the Secretary's decision is required thus does not save it.

b. *Promote Coverage*

At the same time that he failed to consider the *risk* to coverage, the Secretary identified only one element of the Amendments that might *promote* health coverage. In a single sentence, he noted that "a more limited period of retroactive eligibility will encourage bene-

ficiaries to obtain and maintain health coverage, even when they are healthy." AR 8. Little needs to be said on this score. It is well established that "conclusory or unsupported suppositions" do not satisfy the agency's obligation to engage in reasoned decisionmaking. *See McDonnell Douglas Corp. v. U.S. Dep't of Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004). That is particularly so in the face of numerous comments taking the opposite position. As the American Congress of Obstetricians and Gynecologists, among others, explained, limiting retroactive coverage may lead "Medicaid-eligible persons [to] wait even longer to have their conditions treated to avoid incurring medical bills they cannot pay." AR 1279. And when they do eventually arrive for treatment, they will be covered for less time than they would have been before AWA took effect, by definition reducing their Medicaid coverage. *See* AR 1338 (National Health Law Program describing this risk). HHS's brief reference to the potential coverage-promoting effects of the changes to retroactive eligibility thus does not get it across the line.

2. Counterarguments

Defendants offer two separate reasons for the Court to overlook the Secretary's failure to consider coverage, neither of which is persuasive. They say first that the Arkansas Works Amendments promote several other important objectives of Medicaid, including the health of Medicaid-eligible persons. Second, Defendants maintain that any deficiency in the administrative record in this case is cured by the agency's subsequent approval of Kentucky's similar project on remand from the Court's decision in *Stewart I*.

a. *Other Objectives*

Defendants justify the proposed demonstration project on the ground that, regardless of its effect on Medicaid coverage, it advances other objectives of the Act. HHS specifically insists, as it did in *Stewart I*, that the Secretary was on solid ground in finding that the project would improve health outcomes, thereby advancing the goals of Medicaid. *See* HHS MSJ at 17–18. Faced with this argument previously, this Court expressed skepticism that health, generally construed, was properly considered an objective of the Act. *See Stewart I*, 313 F. Supp. 3d at 266. It ultimately held that the agency's "focus on health is no substitute for considering Medicaid's central concern: covering health *costs"* through the provision of free or low-cost health coverage. *Id.* The Court reached the same conclusion in response to assertions that Kentucky HEALTH promoted independence and self-sufficiency. *Id.* at 271–72. HHS has offered no argument here that calls those conclusions into question.

Arkansas presses the point in a somewhat different way, asserting that the provision of Medicaid coverage is (1) the purpose only of Medicaid *appropriations*, not Medicaid, (2) in "irreconcilable tension" with other purposes of the Act, and (3) not applicable to the Medicaid expansion population. *See* Ark. MSJ at 10–22. At the same time, it concedes, seemingly in conflict with its other contentions, that it is "readily apparent" that providing "Medicaid coverage for Medicaid-eligible people" is *"an* objective of Medicaid." *Id.* at 13. The Court has said this before and will say it again: if, as Arkansas and HHS admit (and this Court has found), ensuring Medicaid coverage for the needy is a key objective of the Act, the Secretary's failure to consider the effects of the project on coverage alone

renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the Act.

While the Court might stop there, a brief foray into Arkansas's arguments is nevertheless worthwhile. As to the first, Medicaid is an appropriations statute enacted pursuant to "Congress's power under the Spending Clause." *NFIB*, 567 U.S. at 542. What better place could the purpose of a spending program be found than in the provision that sets up the *"purpose"* of its appropriations? Arkansas's second objection is even more puzzling. The Court does not understand how the objectives of a statute all agree was designed to provide free or low-cost medical care to the needy could nevertheless stand in "irreconcilable tension" with the goal of providing free or low-cost medical care to that population. The third sits on more comprehensible ground, though it yields Arkansas no more success. Addressing the purpose of the Medicaid expansion in *Stewart I*, the Court explained that "the Medicaid statute — taken as a whole — confirms that Congress intended to provide medical assistance to the expansion population." 313 F. Supp. 3d at 269. HHS conceded as much in that case. *Id.* Neither party has offered any reason to retreat from that determination.

Defendants' attempts to find refuge in other purposes of the Act and the propriety of *Chevron* deference as to those purposes are thus all hat, no cattle. Because they agree that the provision of low-cost medical care to Medicaid-eligible persons is a "core" purpose of the Act, *see* HHS Reply at 5, there is no legally significant dispute over the meaning of the Medicaid Act. What matters, instead, is the question addressed above: whether the Secretary adequately considered this issue. As has been made abundantly

clear, he did not. Perhaps understanding as much, HHS largely attempts to justify its approval of the project in this case not on the Arkansas record but on another record entirely.

b. *Kentucky Remand*

This brings the Court to the argument that leads off the Secretary's Reply Brief: that his approval of AWA "is amply justified by the reasoning in his November 20, 2018, approval of Kentucky's materially similar project." HHS Reply at 1. In particular, HHS argues that the project on review here will, like the one approved on remand in Kentucky, help adults "transition from Medicaid to financial independence," thereby enhancing "the fiscal sustainability of Arkansas's Medicaid program" — an objective of the Act. *Id.* at 6. The Government clarified at oral argument that this is not merely a contention against vacatur — although it was principally offered as such — but also an argument in favor of sustaining the Secretary's approval entirely. *See* Tr. at 8–10. The Court addresses the latter position here, leaving the remedy question for the end. In short, three weighty and independent rationales require rejecting HHS's assertion that the Amendments should be approved based on the record in the Kentucky remand proceeding.

First, it runs headlong into the "fundamental rule of administrative law" that a reviewing court "must judge the propriety of such action solely by the grounds invoked by the agency." *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). Nowhere in the Secretary's approval letter does he justify his decision based on concerns about the sustainability of Arkansas's Medicaid program, or on a belief that the project will help Medicaid-eligible persons to gain sufficient financial resources to be able to purchase

private insurance. And the Court "may not accept [] counsel's *post hoc* rationalizations for agency action." *State Farm*, 463 U.S. at 50; *see also Burlington Truck Lines*, 371 U.S. at 168–69 *("Chenery* requires that an agency's discretionary order be upheld, if at all, on the same basis articulated in the order by the agency itself."). The Government responded at oral argument that the Secretary did not need to provide any basis for his decision approving Arkansas's proposed project, so it does not matter on what justification his decision is judicially upheld. *See* Tr. at 9–10. The Court has already explained why that assertion is inconsistent with the APA, *see supra* at 20–21, and it will not spill more ink on the matter here.

HHS's argument suffers from a second and equally significant flaw. The demonstration project under consideration in Kentucky involves different considerations from the Arkansas project, and the rationales in favor of approving one may well not apply to approving the other. The Secretary said as much in opposing this case's designation as related to the Kentucky one. *See* ECF No. 17 ("The two cases involve two separate approvals of two distinct projects in two different States."). Consider the principal arguments the Secretary relies upon on remand in Kentucky. First, he says that the project promotes coverage because in its absence, the expansion population would have no Medicaid coverage. *See Stewart v. Azar*, No. 18-152, ECF No. 108 (HHS MSJ) at 18–20. A necessary ingredient of this argument appears to be that the Kentucky Governor has conditioned the Commonwealth's continued expansion of Medicaid on the Secretary's approval of the proposed project. *Id.* at 19. There is no suggestion that Arkansas's Governor has made any similar kind of threat with regard to the Arkansas Works Amendments. Second, the Secretary

justifies the Kentucky program on the ground that it advances the fiscal sustainability of the state's Medicaid program, which is at risk due to Kentucky's dire budgetary situation. *Id.* at 15–18. Yet there is no assertion that Arkansas is suffering from similar fiscal problems. The Government's argument that the Kentucky approval justifies the decision on review in this case is particularly unpersuasive considering these significant differences.

The final reason to reject this argument is the simplest: the justification the Secretary has given for sustaining Kentucky's program on remand is insufficient and the Court today rejects it in its latest Opinion in *Stewart. See Stewart v. Azar*, No. 18-152, Slip Opinion at 3 (Mar. 27, 2019) *(Stewart II).* If the explanation does not even justify affirmance of Kentucky's project, it cannot support upholding a different administrative decision approving a different state's project.

* * *

In sum, the Secretary's approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address — despite receiving substantial comments on the matter — whether and how the project would implicate the "core" objective of Medicaid: the provision of medical coverage to the needy. Neither his consideration of other Medicaid Act objectives nor his subsequent approval of Kentucky's separate demonstration project cure that deficiency. This failure infected the Secretary's approval of AWA as a whole, such that those Amendments are invalid. The Court will thus grant Plaintiffs full relief on their arbitrary-and-capricious claim, removing any need to address their separate statutory-authority, APA notice-and-comment, and constitutional arguments.

C. Remedy

That leaves only the question of the proper remedy, which in these circumstances is not small beer. When a court concludes that agency action is unlawful, "the practice of the court is ordinarily to vacate the rule." *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997); *Reed v. Salazar*, 744 F. Supp. 2d 98, 119 (D.D.C. 2010) ("[T]he default remedy is to set aside Defendants' action."); *Sierra Club v. Van Antwerp*, 719 F. Supp. 2d 77, 78 (D.D.C. 2010) ("[B]oth the Supreme Court and the D.C. Circuit Court have held that remand, along with vacatur, is the presumptively appropriate remedy for a violation of the APA."). "[A]lthough vacatur is the normal remedy, [courts] sometimes decline to vacate an agency's action." *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014). That decision depends on the "seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change." *Allied-Signal, Inc. v. U.S. Nuclear Reg. Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993) (citation omitted); *see also Standing Rock Sioux Tribe v. U.S. Army Corps of Engineers*, 282 F. Supp. 3d 91, 103 (D.D.C. 2017) (declining to vacate when agency "largely complied" with statute and could likely substantiate prior conclusions on remand).

In *Stewart I*, the Court concluded that both factors supported vacatur. The Government's failure to consider an objective of Medicaid was a "major shortcoming" going "to the heart" of his decision. *See* 313 F. Supp. 3d at 273. And vacatur was not overly disruptive because the project had "yet to take effect" and the plaintiffs could suffer "serious harm[s]" were Kentucky HEALTH allowed to be implemented pend-

ing further proceedings. *Id.* While the journey is somewhat different in this case, the Court arrives at the same destination.

1. *Seriousness of Deficiencies*

The first factor does not favor the Government. For starters, in *Stewart I*, the Court concluded that the same legal error was a "major shortcoming" going "to the heart of the Secretary's decision." 313 F. Supp. 3d at 273. It explained that the D.C. Circuit has "repeatedly vacated agency actions with that flaw." *Id.* Defendants respond that the Secretary has cured the error identified in *Stewart I* on remand, so it will assuredly be able to cure this one upon remand, too. *See* HHS MSJ at 28-29; *see also* Ark. MSJ at 37-38. Not so. As explained at length in *Stewart II*, the Court finds that the remand has not cured this "major shortcoming." *See* Slip Op. at 3, 14–45. Because the agency failed to provide a legally sufficient rationale upon remand from *Stewart I*, the Court is even less sanguine that it will be able to do so in this case than when it vacated the Secretary's Kentucky approval the first time.

This does not mean it will be impossible for the agency to justify its approval of a demonstration project like this one. The Court's decision does not go that far. But after at least two attempts for Kentucky, it has yet to do that analysis. Indeed, HHS may find it *more* difficult to offer a sufficient rationale in its second attempt in this case than in Kentucky. Arkansas does not appear to face the kind of fiscal issues asserted in Kentucky; instead, the state's data suggest that the Medicaid expansion has *reduced* the amount Arkansas will spend on health care for this population between 2017 and 2021. *See* ECF No. 53-6, Exh. 55 (Final Report of Arkansas Health Reform

Legislative Task Force) (explaining that if Arkansas rejects Medicaid expansion, "the negative impact to the state budget is approximately $438 [million]" during this time frame). It stands to reason that the state will have an uphill climb making the case that the expansion has pressed its annual budget, such that eligible persons should be pushed off the rolls. Such fiscal considerations would, in any event, need to be balanced against the more than 16,000 persons who have already lost their coverage because of the new requirements. *See* Arkansas Works Reports at 18, 27, 36, 45. The upshot is that the road to cure the deficiency in this case is, at best, a rocky one, strongly weighing in favor of vacatur.

2. *Seriousness of Disruption*

The second factor is a closer call. Arkansas began implementing its demonstration project in June 2018, imposing work requirements on adults ages 30–49 and implementing the changes to retroactive coverage; it began enforcing work requirements as to adults ages 19–29 in January 2019. HHS and Arkansas assert that any interruption in the project would be enormously disruptive because it would interfere with the "State's data collection efforts," HHS Reply at 22, and "undermine" its "extensive efforts to educate Arkansas Works beneficiaries" on the work requirements. *See* Ark. MSJ at 38–39. They emphasize that, because the Kentucky program had not yet taken effect at the time of its vacatur, these concerns were not present in *Stewart I. Id.* The Court is not insensitive to the practical concerns Defendants raise about pausing enforcement of the Amendments, nor does it take lightly the effect of its ruling upon the state today. For the reasons that follow, however, it finds that the

probable disruptions are not so significant as to require deviation from the ordinary rule of vacatur.

Consider first the nature and extent of the disruptions. If the Court vacates the Secretary's approval of AWA, the state would no longer condition certain Medicaid recipients' coverage on reporting 80 hours of qualifying activities each month and would restore the number of months of retroactive coverage to three. In other words, vacatur would return matters to the way they were before the project was approved. Both changes, HHS asserts, will disrupt the state's data-collection efforts. *See* HHS MSJ at 29. If Arkansas — as the party responsible for collecting and analyzing data from the project — has concerns about data collection in the event of vacatur, it does not say as much. *See* Ark. MSJ at 38–40 (mentioning only disruptive effects on education and outreach); ECF No. 45 (Ark. Reply) (same). Indeed, one amicus points out that the Secretary approved this project without "a proposed evaluation design." *See* Amicus Brief of Deans, Chairs, and Scholars at 19–20.

The Court assumes, however, that vacatur would interrupt the state's efforts to collect data on the effects of the work requirements and changes to retroactive coverage. While such concerns are not insignificant, they are tempered in the context of this case. Experimental projects are intended to help states like Arkansas "test out new ideas" for providing medical coverage to the needy, thereby influencing the trajectory of the federal-state Medicaid partnership down the line. *See supra* S. Rep. No. 1589 at 1961. If, after further consideration or after prevailing on appeal, the Secretary and Arkansas wish to move ahead with work requirements, they will remain able to do so in the future. And if they are dissatisfied with

the data gathered from the initial months of the project because of the interruption caused by vacatur, Defendants could extend the project for an additional period of time to collect more information. This is not to minimize the importance of data collection in the context of an experimental project; it is just to say that vacatur will have little lasting impact on HHS's or Arkansas's interests. That distinguishes this case from others in which the D.C. Circuit has declined to vacate on account of irreversible harms that such a remedy would inflict on the status quo. *See Allied-Signal*, 988 F.2d at 151.

Defendants also maintain that vacatur will harm "Arkansas's education and outreach efforts." Ark. MSJ at 39. In that regard, they explain that a decision invalidating the work requirements will be confusing to Medicaid recipients who have just recently been informed that they have to meet those requirements. *Id.* at 38–39. The Court grants that vacatur of work requirements that have already been implemented may send mixed messages. But any disruption in this respect is not sufficiently significant to avoid vacatur. For one thing, Defendants have expressed confidence throughout this case that they can communicate with Medicaid recipients regarding the terms of the work requirements. *See* HHS MSJ at 8; Ark MSJ at 27, 34–35. If that is so, they should be able to inform them that the requirements are paused for now and, if later reapproved, that they are put back into effect. It bears mentioning here, however, that the State's outreach efforts may well be falling severely short. Notably, only 12.3% of persons not exempt from the requirements reported *any* kind of qualifying activity. *See* Arkansas Works Reports June–November 2018 at 47, 52. The numbers are even lower for several other months. *Id.* Arkansas might use the time while the

program is paused to consider whether and how to better educate persons about the requirements and how to satisfy them. Admittedly, vacatur could make such outreach complicated. Ultimately, however, the Court finds that the harms to prior and ongoing education do not tip the scales against vacatur.

In fact, the structure of the Amendments, considered with the timing of this Opinion, renders vacatur less disruptive that might be expected. As mentioned before, Arkansas Works recipients only lose coverage after three months of non-compliance with the work requirements. *See* AR 31. And the three-month clock starts over at the beginning of the calendar year. *Id.* Because fewer than three months have elapsed in 2019, the work requirements have not yet resulted in anyone's being disenrolled, as such actions cannot take place until April 1. As a consequence, vacatur of the Amendments will not require Arkansas to re-enroll persons who have lost their coverage, with the administrative and communication-related headaches that might entail. Instead, it just requires them to communicate to providers that they should *not* disenroll persons moving forward on account of the requirements. The bottom line: "This is not a case in which the 'egg has been scrambled,' and it is too late to reverse course." *Allina Health*, 746 F.3d at 1110–11 (quoting *Sugar Cane Growers Co-op of Fla. v. Veneman*, 289 F.3d 89, 97 (D.C. Cir. 2002)).

Finally, the Court emphasizes that the disruptions to Arkansas's administration of its Medicaid program must be balanced against the harms that Plaintiffs and persons like them will experience if the program remains in effect. *Cf. A.L. Pharma*, *Inc. v. Shalala*, 62 F.3d 1484, 1492 (D.C. Cir. 1995) (explaining that vacatur inappropriate because "nothing in the record

suggests that significant harm would result from allowing the approval to remain in effect pending the agency's further explanation"); *see also* Tr. at 13 (conceding that court should consider harms to Plaintiffs as part of equitable inquiry into vacatur). Arkansas's own numbers confirm that in 2018, more than 16,000 persons have lost their Medicaid. Defendants offer no reason to think the numbers will be different in 2019; indeed, once the requirements apply to persons aged 19–29, they seem likely to rise. *See* Arkansas Works Reports at 18, 27, 36, 45. Weighing the harms these persons will suffer from leaving in place a legally deficient order against the disruptions to the State's data-collection and education efforts due to vacatur renders a clear answer: the Arkansas Works Amendments cannot stand.

IV. CONCLUSION

For the foregoing reasons, the Court will grant Plaintiffs' Motion for Summary Judgment and deny Defendants' Cross-Motions. A separate Order consistent with this Opinion will issue this day, remanding the matter to HHS.

/s/ James E. Boasberg
JAMES E. BOASBERG
United States District Judge

Date: March 27, 2019

Appendix A

Arkansas Health Plan Component	Comments
Community-Engagement Requirement	AR 1269 (Arkansas Advocates for Children & Families) (noting that the requirement "will increase the rate of uninsured Arkansans" based on comparable effect in TANF program) AR 1277 (American Congress of Obstetricians and Gynecologists, *et al.*) ("The experience of the TANF program . . . demonstrates that imposing work requirements on Medicaid beneficiaries would . . . lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment."); AR 1285 (Families USA) ("The presence of the requirement itself will be a barrier to enrollment, causing some eligible working individuals to forego applying for coverage, and will make it more difficult for some statutorily eligible individuals to maintain coverage."); AR 1291 (AARP) (expressing concern that requirements would "present an unnecessary barrier to health coverage for a sector of Arkansas's population for whom coverage is critical"); AR

1294 (Cystic Fibrosis Foundation) ("We are concerned that this definition [of medically unfit] does not specify what will qualify an individual for exemption, and that people with cystic fibrosis may lose coverage because they are unable to satisfy the requirement due to health status."); AR 1308 (Arkansas Hospital Association) ("These proposed changes . . . will likely lead to increases in churn, gaps in coverage, uninsurance and uncompensated care for hospitals and other providers."); AR 1326 (Legal Aid of Arkansas) (noting that the requirement "would exclude individuals . . . who are partially employable but suffer due to chronic health conditions"); AR 1337 (National Health Law Program) ("The end result of this policy will likely be fewer people with Medicaid coverage and more uninsured people delaying treatment."); AR 1341 (Nat'l Alliance on Mental Illness) ("NAMI Arkansas is concerned that the implementation of mandatory work requirements could cause substantial numbers of people with mental illness to lose health coverage, making it difficult to access mental health care."); AR 1364–65 (Urban Institute Study) (detailing "cover-

	age losses" as consideration for pending Medicaid work-related requirements nationwide and noting "potential adverse impacts on enrollees who have high health care needs but who do not qualify for disability benefits"); AR 1402 (Medicaid and CHIP Payment and Access Commission) (listing an impact on coverage as implication of Medicaid work requirement and noting almost every state proposing requirement had estimated a coverage loss). AR 1421 (Kaiser Family Foundation Issue Brief) (arguing that based on the TANF experience, "a work requirement might result in eligible people losing coverage").
Retroactive Eligibility	AR 1292 (AARP) (warning lack of retroactive coverage would increase debt obligations on previous beneficiaries and would "increase the burden of uncompensated care on providers"); AR 1297 (Human ARC) ("Gaps of time without medical coverage for the low-income population that are eligible and applying for Medicaid will be significant."); AR 1307 (Arkansas Hospital Association) ("AHA is concerned that the waiver of retroactive eligibility will result in unanticipated and avoidable gaps

in coverage and healthcare debt."); AR 1320 (Cancer Action Network) (stating waiver of retroactive eligibility "could place a substantial financial burden on enrollees and cause significant disruptions in care"); AR 1338 (National Health Law Program) ("The entirely predictable result will be . . . more individuals experiencing gaps in coverage when some providers refuse to treat them.").

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 1:18-cv-1900 (JEB)

CHARLES GRESHAM, *et al*.,

Plaintiffs,

v.

ALEX M. AZAR II, *et al*.,

Defendants.

I, Timothy Hill, Acting Director for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services, United States Department of Health and Human Services, under authority delegated to me by the Secretary of Health and Human Services, certify that, to the best of my knowledge, the attached documents constitute a true and complete copy of non-privileged material that CMS considered in approving Arkansas's amendment to Medicaid Section 1115 Demonstration Number 11-W-00287/6.

Dated: October 15, 2018

/s/ Timothy Hill
Timothy Hill

[LOGO] DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare and Medicaid Services
Administrator
Washington, DC 20201

March 5, 2018

The Honorable Asa Hutchinson
Governor
State of Arkansas
500 Woodlane Street
Little Rock, Arkansas 72201

Dear Governor Hutchinson:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works." The details of this approval will be transmitted to Cindy Gillespie, Director of the Arkansas Department of Human Services.

I want to express my appreciation for the hard work and commitment to innovation that your team has displayed during this process. At CMS, we are dedicated to empowering states to better serve their residents through state-led reforms that improve health and help lift individuals out of poverty. Your efforts through this demonstration help us to fulfill that promise.

Congratulations to the entire Arkansas team on reaching approval. We look forward to our continued work together through the implementation of these important reforms.

Sincerely,
[Redacted]
Seema Verma

[LOGO] DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare and Medicaid Services
Administrator
Washington, DC 20201

March 5, 2018

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project. entitled "Arkansas Works" (Project Number 11-W-00287/6) in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective March 5, 2018, through December 31, 2021, upon which date unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement no sooner than June 1, 2018. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Extent and Scope of Demonstration

The current Arkansas Works section 1115 demonstration project was implemented by the State of Arkansas ("state") in December 2016. The Arkansas

Works program provides certain adult Medicaid beneficiaries with premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace. As originally approved. Arkansas Works was designed to leverage the efficiencies and experience of the commercial market to test whether this premium assistance mode improves continuity, access, and quality for Arkansas Works beneficiaries and results in lowering the growth rate of premiums across population groups. The demonstration project also attempts to facilitate transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees. Approval of this demonstration amendment allows Arkansas, no sooner than June 1, 2018, to require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Community engagement requirements will not apply to Arkansas Works beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements. The alignment is appropriate and consistent with the ultimate objective of improving health and well-being for Medicaid beneficiaries.

CMS also is authorizing authorities for additional features, including:

- Removing the requirement to have an approved-hospital presumptive-eligibility state plan amendment (SPA) as a condition of enacting the state's waiver of retroactive eligibility;

- Clarifying the waiver of the requirement to provide new adult group beneficiaries[1] with retroactive eligibility to reflect the state's intent to not provide retroactive eligibility but for the 30 days prior to the date of application coverage; and
- Removing the waiver and expenditure authorities related to the state's mandatory employer-sponsored insurance (ESI) premium assistance program, as the state no longer intends to continue this program.

Under the new community engagement program, the state will test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence. CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program. The terms and conditions of Arkansas's community engagement requirement that accompany this approval are consistent with the guidance provided to states through State Medicaid Director's Letter (SMD 18-0002), Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued on January 11, 2018. CMS is not at this time approving Arkansas's request to reduce income eligibility for Arkansas Works beneficiaries to 100 percent of the federal poverty level (FPL).

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[1] This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Determination that the demonstration project is likely to assist in promoting Medicaid's Objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstrations are likely to assist in promoting the objectives of Medicaid.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration programs are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness, including measures to help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

In its consideration of the proposed changes to Arkansas Works, CMS examined whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined that the Arkansas Works demonstration as amended is likely to promote Medicaid objectives, and that the waivers sought are

necessary and appropriate to carry out the demonstration.

1. The demonstration is likely to assist in improving health outcomes through strategies that promote community engagement and address certain health determinants.

Arkansas Works supports coordinated strategies to address certain health determinants, as well as promote health and wellness through increased upward mobility, greater independence, and improved quality of life. Specifically, Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness.[2,3] As noted in CMS' SMDL: 18-0002, these activities have been positively correlated with improvements in individuals' health. CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities.

Given the potential benefits of work and community engagement, we believe that state Medicaid programs should be able to design and test incentives for beneficiary compliance. Under Arkansas's demonstration, the state will encourage compliance by making it a condition of continued coverage. Beneficiaries that

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[2] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[3] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper, K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

successfully report compliance on a monthly basis will have no disruption in coverage. It is only when a beneficiary fails to report compliance for 3 months that the state will dis-enroll the beneficiary for the remainder of the calendar year. Beneficiaries that are disenrolled from their plan will be able to re-enroll through Arkansas Works upon the earlier of turning age 50, qualifying for another category of Medicaid eligibility, or the beginning of a new calendar year.

Arkansas' approach is informed by the state's experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be be sufficient to encourage the Arkansas Works population to participate in community engagement activities. CMS will therefore allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

Arkansas has tailored the incentive structure to include beneficiary protections, such as an opportunity to maintain coverage for beneficiaries who report that they failed to meet the community engagement hours due to circumstances that give rise to a good cause exemption, as well as the opportunity to apply and reenroll in Arkansas Works in the beginning of the next plan year. Additionally, if Arkansas determines that a beneficiary's failure to comply or report

compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive retroactive coverage to the date coverage ended without *need* for a new application. The impact of this incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, and health outcomes over time for persons subject to the demonstration's policies.

2. The demonstration is expected to strengthen beneficiary engagement in their personal health care.

CMS believes that it is important for beneficiaries to engage in their personal health care, particularly while they are healthy to prevent illness. Accordingly, CMS supports state testing of policies designed to incentivize beneficiaries to obtain and maintain health coverage before they become sick so they can take an active role in engaging in their personal health care while healthy. Consistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage (stated in the letter to governors on March 14, 2017), this amendment removes the requirement that Arkansas provide hospitals with an opportunity to conduct presumptive eligibility (consistent with Section 1902(a)(47)(B)) as a condition of its waiver of retroactive eligibility. It further clarifies the waiver of the requirement to provide new adult group beneficiaries with retroactive eligibility but for the 30 days prior to the date of application coverage. With respect to the waiver of retroactive eligibility, through this approval, we are testing whether eliminating 2 of the 3 months of retroactive coverage will encourage

beneficiaries to obtain and maintain health coverage, even when they are healthy. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick with the ultimate objective of improving beneficiary health.

Consideration of Public Comments

Both Arkansas and CMS received comments during the state and federal public comment periods. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all the public comments it received, when evaluating whether the demonstration project as a whole was likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought were necessary and appropriate to implement the demonstration. In addition, CMS took public comments submitted during the federal comment period into account as it worked with Arkansas to develop the STCs that accompany this approval that will bolster beneficiary protections, including specific state assurances around these protections to further support beneficiaries.

Opposing commenters expressed general disagreement with efforts to modify Arkansas Works. Some offered more specific feedback regarding individual elements of the demonstration or the impact of certain provisions on distinct populations. Some commenters expressed the desire to see greater detail regarding how the program would be operationalized, particularly with respect to provisions like the community engagement requirements. Other comments expressed concerns that these requirements would be burdensome on families or create barriers to coverage. The

state has pledged to do beneficiary outreach and education on how to comply with the new community engagement requirements, and intends to use an online reporting system to make reporting easy for enrollees. Further, CMS intends to monitor state-reported data on how the new requirements are impacting enrollment.

Many commenters indicated that many beneficiaries not qualifying for Medicaid on the basis of disability may still have issues gaining and maintaining employment due to their medical or behavioral health conditions. To mitigate these concerns, Arkansas assures that it will provide these beneficiaries reasonable modifications, which could include the reduction of or exemption from community engagement hours. This is a condition of approval, as provided in the STCs.

Some commenters expressed concern that Arkansas's proposal "lacked sufficient detail to permit informed public comments." To ensure meaningful public input at the Federal level, and to facilitate the demonstration application process for States, CMS utilizes standardized demonstration application requirements so that the public, including those with disabilities, and CMS can meaningfully assess states' applications. Upon receipt of Arkansas' proposal, CMS followed its standard protocols for evaluating the completeness of the application and determined that Arkansas application was complete. We continue to believe that Arkansas submitted sufficient detail to permit meaningful public input.

Many commenters who opposed the community engagement requirement emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to

coverage for non-exempt people who might have trouble accessing care. We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence. However, CMS has included provisions in these STCs to ensure that CMS may withdraw waivers or expenditure authorities at any time if federal monitoring of data indicates that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and Title XXI, including if data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. In efforts to support beneficiaries, CMS will require Arkansas to provide written notices to beneficiaries that include information such as how to ensure that they are in compliance with the community engagement requirements, how to appeal an eligibility denial, and how to access primary and preventive care during the non-eligibility period. The state will also implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements.

Additional comments characterized the provisions to terminate coverage for failure to participate in the community engagement process as "causing disruptions in care." CMS and Arkansas acknowledged these concerns and Arkansas will be exempting from the requirement those individuals who are medically frail,

as well as those whom a medical professional has determined are unable to work due to illness or injury. The state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

Several commenters expressed concern about the potential 9-month length of the non-eligibility period. This would only occur where (i) an individual fails to fulfill his or her community engagement obligations in the first month of a calendar year and then after receiving a notice from the State in the second month, fails to respond to that notice by rectifying the situation or seeking an exemption, (ii) the same individual fails to fulfill his or her community engagement obligations in the second month of a calendar year and then after receiving a notice from the State in the third month, fails to respond to that notice by rectifying the situation or seeking an exemption, and (iii) the same individual fails to fulfill his or her community engagement obligations in the third month of a calendar year and then after receiving a notice from the State in the fourth month, fails to respond to that notice by rectifying the situation or seeking an exemption. The program provides the individual with three opportunities to rectify the situation or seek an exemption. Any system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals. We believe that the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to

those who fail to respond and who fail to seek exemption from the programs limited requirements.

Some comments pointed out that the maximum non-eligibility period is longer than what has been proposed in other state demonstration applications, and does not offer any way to regain eligibility during the non-eligibility period. CMS acknowledges this and Arkansas will be required to monitor and report to CMS certain metrics on compliance rates and health outcomes. CMS will closely monitor this data, and retains the right to suspend, amend or terminate the demonstration if the agency determines that it is not meeting its stated objectives.

Other commenters expressed concern about Arkansas' current eligibility and application operations and their impact on beneficiaries who may reapply for eligibility after serving their disenrollment period for non-compliance with community engagement. To help mitigate these concerns, CMS has added additional assurances to the STCs and Arkansas will submit for CMS approval an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration which will allow CMS to track Arkansas' compliance with the assurances described in the STCs, including several related to eligibility and application processing systems. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed the application processing monitoring plan for completeness and determined that the state has addressed all of the required elements in a reasonable manner. As part of this requirement, CMS will require that Arkansas provide status updates on the implementation of the eligibility and enrollment monitoring plan in the state's quarterly reports.

Finally, many comments expressed concern over the waiver of retroactive eligibility, citing disruptions in care for beneficiaries and potential financial burdens for both providers and beneficiaries. Arkansas had previously received approval for a conditional waiver of retroactive coverage conditioned upon the state coming into compliance with statutory and regulatory requirements related to eligibility determinations. CMS has determined the state has met these requirements. CMS believes that a more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. As such, with this amendment we are testing whether this limited retroactive eligibility period supports increased continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick and whether this feature will improve health outcomes.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Tia Witherspoon. She is available to answer any questions concerning your section 1115 demonstration. Ms. Witherspoon's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17

7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Tia. Witherspoon@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Witherspoon and Mr. Bill Brooks, Associate Regional Administrator, in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's
Health Operations
1301 Young Street, Suite 833
Dallas, TX 75202

If you have questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Arkansas, over the past months to reach approval.

Sincerely,
[redacted]
Seema Verma

Enclosures

CENTERS FOR MEDICARE AND MEDICAID SERVICES EXPENDITURE AUTHORITY

NUMBER: 11-W-00287/6

TITLE: Arkansas Works Section 1115 Demonstration

AWARDEE: Arkansas Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditure under section 1903 shall, for the period of this demonstration be regarded as expenditures under the state's Title XIX plan but are further limited by the special terms and conditions (STCs) for the Arkansas Works Section 1115 demonstration.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Arkansas Works section 1115 demonstration, including the granting of the waiver and expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Social Security Act.

The following expenditure authorities shall enable Arkansas to implement the Arkansas Works section 1115 demonstration:

1. Premium Assistance and Cost Sharing Reduction Payments. Expenditures for part or all of the cost of private insurance premiums in the individual market, and for payments to reduce cost sharing under such coverage for certain beneficiaries as described in these STCs.

2. Community Engagement Reporting. Expenditures to the extent necessary to enable Arkansas to allow a beneficiary to report monthly their community engagement qualifying activities or exemptions using only an online portal as described in these STCs, in a manner inconsistent with requirements under section 1943 of the Act as implemented in 42 CFR 435.907(a).

Requirements Not Applicable to the Expenditure Authority:

1. Cost Effectiveness	Section 1902(a)(4) and 42 CFR 435.1015(a)(4)

To the extent necessary to permit the state to offer, with respect to beneficiaries through qualified health plans, premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness as described in these STCs.

CENTERS FOR MEDICARE &
MEDICAID SERVICES

WAIVER LIST

NUMBER: 11-W-00287/6

TITLE: Arkansas Works Section 1115 Demonstration

AWARDEE: Arkansas Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective March 5, 2018 through December 31, 2021. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted for the Arkansas Works Section 1115 demonstration, subject to the STCs.

1. Freedom of Choice — Section 1902(a)(23)(A)

To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

2. Payment to Providers — Section 1902(a)(13) and Section 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. Prior Authorization	Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)

To permit Arkansas to require that requests for prior authorization for drugs be addressed within 72 hours, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances as is currently required in their state policy. A 72- hour supply of the requested medication will be provided in the event of an emergency.

4. Premiums	Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A

To the extent necessary to enable Arkansas to collect monthly premium payments, for beneficiaries with incomes above 100 up to and including 133 percent of the federal poverty level (FPL) as described in these STCs.

5. Comparability	Section 1902(a)(10)(B)

To the extent necessary to enable the state to impose targeted cost sharing on beneficiaries as described in these STCs.

6. Retroactive Eligibility	Section 1902(a)(34)

To enable the state to not provide beneficiaries in table 1 retroactive eligibility but for 30 days prior to the date of the application for coverage under the demonstration.

7. Provision of Medical Assistance	Section 1902(a)(8) and Sections 1902(a)(10)

To the extent necessary to enable Arkansas to terminate eligibility for, and not make medical assistance available to, Arkansas Works beneficiaries who

fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted as described in these STCs.

8. Eligibility Section 1902(a)(10)

To the extent necessary to enable Arkansas to require community engagement as a condition of eligibility as described in these STCs.

To the extent necessary to enable Arkansas to prohibit re-enrollment and deny eligibility, for up to nine months for Arkansas Works program beneficiaries who are disenrolled for failure to timely report community engagement qualifying activities and exemptions for three months, subject to qualifying catastrophic events described in these STCs.

CENTERS FOR MEDICARE AND MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00287/6

TITLE: Arkansas Works

AWARDEE: Arkansas Department of Human Services

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Works section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Arkansas Department of Human Services (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. Enrollment into the demonstration is statewide and is approved through December 31, 2021. The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Arkansas Works demonstration, the state has been providing premium assistance to support the purchase by beneficiaries eligible under the new adult group under the state plan of coverage from qualified health plans (QHPs) offered in the individual market through the Marketplace. Enrollment activities for the new adult population began on October 1, 2013 for QHPs with eligibility effective January 1, 2014. Beginning in 2014, individuals eligible for coverage under the new adult group are described at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and are further specified in the state plan (collectively Arkansas Works beneficiaries). Arkansas Works beneficiaries receive a state plan Alternative Benefit Plan ("ABP").

Effective January 1, 2017, Arkansas Works beneficiaries with incomes above 100 percent of the FPL are charged monthly premium payments. The state will test innovative approaches to promoting community

engagement and work, encouraging movement up the economic ladder, and facilitating transitions between and among Arkansas Works, employer sponsored insurance (ESI), and the Marketplace for Arkansas Works beneficiaries. The state will institute community engagement requirements as a condition of Arkansas Works eligibility. Once community engagement requirements are fully implemented, including that beneficiaries have been adequately notified of the requirements, the state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities. Arkansas will also provide reasonable accommodations for beneficiaries who request assistance due to barriers to accessing the online portal for reporting. Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, or job search activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who fail to meet the community engagement requirements or reporting requirements for any three months during a plan year will be disenrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year. After the beneficiary receives notification of disenrollment for either noncompliance with community engagement requirements or for failure to report, eligible beneficiaries may request a good cause exemption as described in these STCs. If Arkansas determines the beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive

retroactive coverage to the date coverage ended without need for a new application. Arkansas will act on the request for good cause exemption and, if approved, restore the beneficiary's coverage within 5 business days of receiving the request.

Finally, the state will eliminate its ESI premium assistance program under the demonstration. All Arkansas Works beneficiaries who were enrolled in ESI premium assistance and who remain eligible for Arkansas Works will transition to QHP coverage.

Over the demonstration period, the state seeks to demonstrate several demonstration goals. The state's goals will inform the state's evaluation design hypotheses, subject to CMS approval, as described in these STCs. The state's goals include, and are not limited to the following:

- Providing continuity of coverage for individuals,
- 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 that are successful across population groups.

Arkansas proposes that the demonstration will provide integrated coverage for low-income Arkansans, leveraging the efficiencies and experience of the

private market to improve continuity, access, and quality for Arkansas Works beneficiaries that should ultimately result in lowering the rate of growth in premiums across population groups. The state proposes that the demonstration will also drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace by at least doubling the size of the population enrolling in QHPs offered through the Marketplace. The state proposes to demonstrate the following key features:

Continuity of coverage and care – The demonstration will allow qualifying households to stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, or Advanced Premium Tax Credits/Cost Sharing Reductions (APTC/CSRs).

Support equalization of provider reimbursement and improve provider access – The demonstration will support equalization of provider reimbursement across payers, toward the end of expanding provider access and eliminating the need for providers to cross-subsidize. Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to "cross subsidize" their Medicaid patients by charging more to private insurers.

Integration, efficiency, quality improvement and delivery system reform – Arkansas is proposing taking an integrated and market-based approach to covering uninsured Arkansans. It is anticipated that QHPs will bring the experience of successful private sector models that can improve access to high quality services and lead delivery system reform. One of the benefits of this demonstration should be to gain a

better understanding of how the private sector uses incentives to engage individuals in healthy behaviors.

Promoting community engagement and personal responsibility– By testing innovative approaches to promoting community engagement as a condition of eligibility, the demonstration aims to incentivize employment.

III. GENERAL PROGRAM REQUIREMENTS

1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or

changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

   Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state

must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. Changes Subject to the Amendment Process. If not otherwise specified in these STCs, changes related to demonstration features including eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan and/or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;

b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c)

or a transition and phase-out plan consistent with the requirements of STC 9.

a. Compliance with Transparency Requirements at 42 CFR Section 431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan Amendment, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised plan.

b. Prior CMS Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 calendar days after CMS approval of the plan.

c. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant is entitled to requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).

f. Federal Financial Participation (FFP). If the demonstration is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of participant's appeals and administrative costs of disenrolling participants.

10. Pre-Approved Transition and Phase Out Plan. The state may elect to submit a draft transition and phase-out plan for review and approval at any time, including prior to when a date of termination has been identified. Once the transition and phase-out plan has been approved, implementation of the plan may be delayed indefinitely at the option of the state.

11. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling beneficiaries.

12. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the State must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's

expiration date, consistent with the following requirements:

a. Expiration Requirements. The State must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The State must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Section 431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the State's demonstration expiration plan. CMS will consider comments received during the 30-

day period during its review and approval of the State's demonstration expiration plan. The State must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan. d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling beneficiaries.

13. Withdrawal of Demonstration Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX, including if federal monitoring of data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling beneficiaries.

14. Adequacy of Infrastructure. The State must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.

    a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

    b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal,

amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

16. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ARKANSAS WORKS PROGRAM POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Arkansas Works eligible beneficiaries provided primarily through QHPs offered in the individual market instead of the fee-for-service delivery

system that serves the traditional Medicaid population. The State will provide premium assistance to aid Arkansas Works beneficiaries in enrolling in coverage through QHPs in the Marketplace.

18. Populations Affected by the Arkansas Works Demonstration. Except as described in STCs 19 and 20, the Arkansas Works demonstration affects adults aged 19 through 64 eligible under the state plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119. Eligibility and coverage for Arkansas Works beneficiaries is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid state plan amendments to this eligibility group, including the conversion to a modified adjusted gross income (MAGI) standard on January 1, 2014, will apply to this demonstration.

Table 1. Eligibility Groups

Medicaid State Plan, Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
New Adult Group	This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in section 1902(a)(10)(A)(i)(VIII)	Title XIX	MEG-1

19. Beneficiary is medically frail. The process is described in the Alternative Benefit state plan. Beneficiaries excluded from enrolling in QHPs

through the Arkansas Works as a result of a determination of medical frailty as that term is defined above will have the option of receiving direct coverage through the state of either the same ABP offered to the beneficiaries or an ABP that includes all benefits otherwise available under the approved Medicaid state plan (the standard Medicaid benefit package). Direct coverage will be provided through a fee- for- service (FFS) system.

20. American Indian/Alaska Native Individuals. Beneficiaries identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHPs in this demonstration, but can choose to opt into a QHP. New applicants will be subject to provisions of STC 21 and coverage will begin 30 days prior to the date an application is submitted for coverage. Beneficiaries who are AI/AN and who have not opted into a QHP will receive the ABP through a fee for service (FFS) system. An ALAN beneficiary will be able to access covered benefits through Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, I/T/U) facilities funded through the IHS. Under the Indian Health Care Improvement Act (IHCIA), I/T/U facilities are entitled to payment notwithstanding network restrictions.

21. Retroactive Eligibility. The state will provide coverage effective 30 days prior to the date of submitting an application for coverage for beneficiaries in table 1.

V. ARKANSAS WORKS PREMIUM ASSISTANCE ENROLLMENT

22. Arkansas Works. For Arkansas Works beneficiaries, except as noted in STCs 19 and 20, enrollment in a QHP is a condition of receiving benefits.

23. Notices. Arkansas Works beneficiaries will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:

    a. QHP Plan Selection. The notice will include information regarding how Arkansas Works beneficiaries can select a QHP and information on the State's auto-assignment process in the event that the beneficiary does not select a plan.

    b. State Premiums and Cost-Sharing. The notice will include information about the beneficiary's premium and cost-sharing obligations, if any, as well as the quarterly cap on premiums and cost-sharing.

    c. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

    d. Wrapped Benefits. The notice will also include information on how beneficiaries can access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid and what phone numbers to call or websites to visit to access wrapped services.

    e. Appeals. The notice will also include information regarding the grievance and appeals process.

    f. Identification of Medically Frail. The notice will include information describing how Arkansas Works beneficiaries who believe they are medically frail can request a determination of whether they are exempt from the ABP. The

notice will also include alternative benefit plan options.

g. Timely and adequate notice concerning adverse actions. The notice must give beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid in accordance with 42 CFR 435.919.

24. QHP Selection. The QHPs in which Arkansas Works beneficiaries enroll are certified through the Arkansas Insurance Department's QHP certification process. The QHPs available for selection by the beneficiary are determined by the Medicaid agency.

25. Auto-assignment. In the event that an beneficiary is determined eligible for coverage through the Arkansas Works QHP premium assistance program, but does not select a plan, the State will auto-assign the beneficiary to one of the available QHPs in the beneficiary's rating area. Beneficiaries who are auto-assigned will be notified of their assignment, and the effective date of QHP enrollment, and will be given a thirty-day period from the date of enrollment to request enrollment in another plan.

26. Distribution of Members Auto-assigned. Arkansas Works QHP auto-assignments will be distributed among QHP issuers in good standing with the Arkansas Insurance Department offering certified silver-level QHPs certified by the Arkansas Insurance Department.

27. Changes to Auto-assignment Methodology. The state will advise CMS prior to implementing a change to the auto-assignment methodology.

28. Disenrollment. Beneficiaries may be disenrolled from the demonstration if they are determined to be medically frail after they were previously determined eligible.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

29. Memorandum of Understanding for QHP Premium Assistance. The Arkansas Department of Human Services and the Arkansas Insurance Department have entered into a memorandum of understanding (MOU) with each QHP that enrolls beneficiaries. Areas to be addressed in the MOU include, but are not limited to:

    a. Enrollment of beneficiaries in populations covered by the demonstration;

    b. Payment of premiums and cost-sharing reductions, including the process for collecting and tracking beneficiary premiums;

    c. Reporting and data requirements necessary to monitor and evaluate the Arkansas Works including those referenced in STC 79, ensuring beneficiary access to EPSDT and other covered benefits through the QHP;

    d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR 431.420(f)(2), to CMS or CMS' evaluation contractors.

e. Noticing requirements; and

f. Audit rights.

30. Qualified Health Plans. The State will use premium assistance to support the purchase of coverage for Arkansas Works beneficiaries through Marketplace QHPs.

31. Choice of QHPs. Each Arkansas Works beneficiary required to enroll in a QHP will have the option to choose between at least two silver plans covering only Essential Health Benefits that are offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums.

    a. Arkansas Works beneficiaries will be able to choose from at least two silver plans covering only Essential Health Benefits that are in each rating area of the State.

    b. Arkansas Works beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area and that meet the purchasing guidelines established by the State in that year, and thus all Arkansas Works beneficiaries will have a choice of at least two QHPs.

    c. The State will comply with Essential Community Provider network requirements, as part of the QHP certification process.

    d. Arkansas Works beneficiaries will have access to the same networks as other beneficiaries enrolling in QHPs through the individual Marketplace.

32. Coverage Prior to Enrollment in a QHP. The State will provide coverage through fee-for-service

Medicaid from the date a beneficiary is determined eligible until the beneficiary's enrollment in the QHP becomes effective.

a. For beneficiaries who enroll in a QHP (whether by selecting the QHP or through auto-assignment) between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP enrollment.

b. For beneficiaries who enroll in a QHP (whether by selecting the QHP or through auto-assignment) between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

33. Family Planning. If family planning services are accessed at a facility that the QHP considers to be an out-of-network provider, the State's fee-for-service Medicaid program will cover those services.

34. NEMT. Non-emergency medical transport services will be provided through the State's fee-for-service Medicaid program. See STC 41 for further discussion of non-emergency medical transport services.

VII. BENEFITS

35. Arkansas Works Benefits. Beneficiaries affected by this demonstration will receive benefits as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2). These benefits are described in the Medicaid state plan.

36. Alternative Benefit Plan. The benefits provided under an alternative benefit plan for the new adult group are reflected in the State ABP state plan.

37. Medicaid Wrap Benefits. The State will provide through its fee-for-service system wrap-around benefits that are required for the ABP but not covered by QHPs. These benefits include non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for beneficiaries participating in the demonstration who are under age 21.

38. Access to Wrap Around Benefits. In addition to receiving an insurance card from the applicable QHP issuer, Arkansas Works beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. This information is also posted on Arkansas Department of Human Service's Medicaid website and will be provided through information at the Department of Human Service's call centers and through QHP issuers.

39. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

40. Access to Federally Qualified Health Centers and Rural Health Centers. Arkansas Works beneficiaries will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC.

41. Access to Non-Emergency Medical Transportation. The state will establish prior authorization for

NEMT in the ABP. Beneficiaries served by IHS or Tribal facilities and medically frail beneficiaries will be exempt from such requirements.

42. Incentive Benefits. To the extent an amendment is approved by CMS, Arkansas will offer an additional benefit not otherwise provided under the Alternative Benefit Plan for Arkansas Works beneficiaries who make timely premium payments (if above 100 percent FPL) and engage with a primary care provider (PCP). Arkansas Works beneficiaries with incomes at or below 100 percent FPL and others who are exempt from premiums will be eligible for an incentive benefit at the time the amendment is approved.

VIII. PREMIUMS & COST SHARING

43. Premiums & Cost Sharing. Cost sharing for Arkansas Works beneficiaries must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447.56(a).

44. Premiums & Cost Sharing Parameters for the Arkansas Works Program. With the approval of this demonstration:

    a. Beneficiaries up to and including 100 percent of the FPL will have no cost sharing.

    b. Beneficiaries above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements.

    c. Beneficiaries above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income.

d. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.

e. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program beneficiaries.

f. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the state's approved state plan; premium, copayment, and coinsurance amounts are listed in Attachment B.

45. Payment Process for Payment of Cost Sharing Reduction to QHPs. Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for Arkansas Works beneficiaries. Such payments will be subject to reconciliation at the conclusion of the benefit year based on actual expenditures by the QHP for cost sharing reduction. If a QHP issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the QHP issuer will be entitled to during reconciliation, the QHP issuer may ask Arkansas' Department of Human Services to adjust the advance payments. Arkansas' reconciliation process will follow 45 CFR Section 156.430 to the extent applicable.

46. Grace Period/Debt Collection. Arkansas Works beneficiaries will have two months from the date of the payment invoice to make the required monthly premium contribution. Arkansas and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report

the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for beneficiaries at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.

IX. APPEALS

47. Beneficiary safeguards of appeal rights will be provided by the State, including fair hearing rights. No waiver will be granted related to appeals. The State must ensure compliance with all federal and State requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the State has submitted a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department.

X. COMMUNITY ENGAGEMENT REQUIREMENTS

48. Overview. Subject to these STCs, the state will implement a community engagement requirement as a condition of continued eligibility for Arkansas Works members below the age of 50 who are not otherwise subject to an exemption described in STC 49 or 53(a). To maintain Medicaid eligibility, non-exempt members will be required to participate in specified activities that may include employment, education or community services, as specified in these STCs. The work requirements will be implemented no sooner than June 1, 2018, and the state will provide CMS with notice 30 days prior to its implementation.

49. Exempt Populations. The Arkansas Works beneficiaries below are exempt from the community engagement requirements. Beneficiaries who report, in accordance with 42 CFR 435.945(a) that they meet one or more of the following exemptions will not be required to complete community engagement related activities to maintain eligibility:

    - Beneficiaries identified as medically frail (under 42 CFR 440.315(f) and as defined in the alternative benefit plan in the state plan)
    - Beneficiaries who are pregnant or 60 days post-partum
    - Full time students
    - Beneficiary is exempt from Supplemental Nutrition Assistance Program (SNAP) community engagement requirements
    - Beneficiary is exempt from Transitional Employment Assistance (TEA)[1] Cash Assistance community engagement requirements
    - Beneficiary receives TEA Cash Assistance
    - Beneficiary is incapacitated in the short-term, is medically certified as physically or mentally unfit for employment, or has an acute medical condition validated by a medical professional that would prevent him or her from complying with the requirements

[1] Arkansas' Temporary Assistance for Needy Families (TANF) program.

- Beneficiary is caring for an incapacitated person
- Beneficiary lives in a home with his or her minor dependent child age 17 or younger
- Beneficiary is receiving unemployment benefits
- Beneficiary is currently participating in a treatment program for alcoholism or drug addiction

Beneficiaries who report that they meet one or more of the above listed exemptions will not be required to complete community engagement related qualifying activities to maintain eligibility. Upon initial notice that a beneficiary must commence community engagement activities, the beneficiary may report an exemption at any time, via electronic submission. Consistent with STC 52, Arkansas will also provide web sites that comply with federal disability rights laws and reasonable accommodations for beneficiaries who are unable to report, or have difficulty reporting, work activities to ensure that they have an equal opportunity to report their participation

50. Qualifying Activities. Arkansas Works beneficiaries who are not exempt under STC 49 may satisfy their community engagement requirements through a variety of activities, including but not limited to:

    - Employment or self-employment, or having an income that is consistent with being employed or self-employed at least 80 hours per month[2]

[2] Arkansas minimum wage is used as a proxy amount to determine this income standard. As of 2017, minimum wage is

- Enrollment in an educational program, including high school, higher education, or GED classes
- Participation in on-the-job training
- Participation in vocational training
- Community Service
- Participation in independent job search (up to 40 hours per month)
- Participation in job search training (up to 40 hours per month)
- Participation in a class on health insurance, using the health system, or 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/Transitional Employment Assistance (TEA) employment initiative programs.

51. Hour Requirements. Arkansas Works beneficiaries must complete at least 80 hours per calendar month of one, or any combination, of the qualifying activities listed in STC 50. Beneficiaries will be required to electronically report into the online portal by the 5th of each month for the previous month's qualifying activities. Arkansas will also provide reasonable accommodations to ensure that

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$8.50 per hour. Multiplied by 80 hours per month, an individual is considered to be in compliance with the community engagement requirements if they have income or earnings of at least $736 per month.

beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, who are unable to report, or have difficulty reporting, work activities to ensure that they have an equal opportunity to report their participation and therefore to have an equal opportunity to participate in, and benefit from, the program. If the state is unable to provide such a modification to the reporting requirements as required by federal law, then the state must follow the requirements of STC 52, which would require that the state provide a modification in the form of an exemption from participation.

52. Reasonable Modifications. Arkansas must provide reasonable accommodations related to meeting the community engagement requirements for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The state must also provide reasonable modifications for program protections and procedures, including but not limited to, assistance with demonstrating eligibility for good cause exemptions; appealing disenrollments; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. The reasonable modifications must include exemptions from participation where an individual is unable to participate or report for disability-related reasons,

modification in the number of hours of participation required where an individual is unable to participate for the otherwise-required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

53. Non-Compliance. Beneficiaries who are subject to community engagement and reporting requirements and do not comply with the requirements will lose eligibility for Arkansas Works consistent with the terms of these STCs. Beneficiaries who submit an appeal request or report a good cause exemption prior to disenrollment will maintain services as provided under 42 CFR 431.230.

    Beneficiaries who fail to meet the required community engagement hours or fail to report for any month within a coverage year before they are disenrolled for non-compliance will receive timely and adequate monthly notices in writing to inform them of noncompliance and how to come into compliance.

    a. Good Cause Exemption. The state will not count any month of non-compliance with the community engagement requirement or reporting requirements toward the three months under this STC for beneficiaries who demonstrate good cause for failing to meet the community engagement hours otherwise required for that month. The circumstances constituting good cause must have occurred during the month for which the beneficiary is seeking a good cause exemption. The recognized good cause exemp-

tions include, but are not limited to, at a minimum, the following verified circumstances:

i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;

ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;

iii. The beneficiary experiences severe inclement weather (including a natural disaster) that renders him or her unable to meet the requirement; or

iv. The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence).

b. Disenrollment Effective Date. Disenrollment for non-compliance with the community engagement requirements is effective the first day of the month after proper notice is provided during the third month of non-compliance, unless an appeal is timely filed as specified in STC 54(i) or a good cause exemption is requested as specified in STC 53(a).

c. Re-enrollment Following Non-Compliance. If the beneficiaries are noncompliant with the community engagement requirements or reporting requirements for any three months, eligibility will be terminated until the next plan year, when they must file a new application to receive an eligibility determination. At this time, their previous noncompliance with the community engagement requirement will not be factored into the state's determination of their eligibility. A beneficiary who is disenrolled pursuant to this STC can reapply at any time for coverage and will be eligible to enroll with an effective date consistent with the regulations at 42 CFR. 435.915, (1) if she or he is determined eligible for another eligibility group, or (2) the beneficiary would have qualified for a good cause exemption at the time of disenrollment and Arkansas determines the beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, Such beneficiaries who experienced catastrophic events or circumstances beyond their control will receive retroactive coverage to the date coverage ended without need for a new application. Arkansas will act on the request for good cause exemption and, if approved, restore the beneficiary's coverage within 5 business days of receiving the request.

54. Community engagement requirements: State Assurances. Prior to implementation of community engagement requirements as a condition of eligibility, the state will:

a. Maintain mechanisms to stop payments to a QHP when a beneficiary is terminated for failure to comply with program requirements.

b. Ensure that there are processes and procedures in place to seek data from other sources including SNAP and Temporary Assistance for Needy Families (TANF), and that the state uses available systems and data sources to verify that beneficiaries are meeting community engagement requirements.

c. To the extent that it is required by SNAP, beneficiaries who participate in both SNAP and Arkansas Works will have the option of reporting community engagement activities through either program. If a beneficiary reports activities through SNAP, Arkansas will transfer the individual's file to Arkansas Works to satisfy reporting for both programs. In accordance with all applicable federal and state reporting requirements, beneficiaries enrolled in and compliant with a SNAP work requirement, as well as individuals exempt from a SNAP work requirement, will be considered to be complying with the Arkansas Works community engagement requirements without further need to report.

d. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:

    i. When community engagement requirements will commence for that specific beneficiary;

    ii. Whether a beneficiary is exempt, how the beneficiary must apply for and document that she or he meets the requirements for an

exemption, and under what conditions the exemption would end;

iii. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting community engagement requirements;

iv. Information about how community engagement hours will be counted and documented;

v. What gives rise to disenrollment, what disenrollment would mean for the beneficiary, including how it could affect redetermination, and how to avoid disenrollment, including how to apply for a good cause exemption and what kinds of circumstances might give rise to good cause;

vi. If a beneficiary is not in compliance for a particular month, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can be in compliance in the month immediately following;

vii. If a beneficiary has eligibility denied, how to appeal, and how to access primary and preventive care during the non-eligibility period.

viii. If a beneficiary has requested a good cause exemption, that the good cause exemption has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

e. Conduct active outreach and education beyond standard noticing for Arkansas Works bene-

ficiaries for successful compliance with community engagement requirements as clients move toward self-sufficiency and economic security.

f. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions or alternative compliance standards from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet in impacted areas.

g. Develop and maintain an ongoing partnership with the Arkansas Department of Workforce Services to assist Arkansas Works recipients with complying with community engagement requirements and moving toward self-sufficiency.

h. Leverage the ongoing partnership with QHPs participating in the Arkansas Works premium assistance model for continued outreach, education and encouragement to comply with community engagement requirements.

i. Provide full appeal rights, consistent with all federal statute and regulation, prior to disenrollment and observe all requirements for due process for beneficiaries who will be disenrolled for failing to comply with the applicable community engagement requirements, including allowing beneficiaries the opportunity to raise additional issues in a hearing (in addition to whether the beneficiary should be subject to

termination) or provide additional documentation through the appeals process.

j. Maintain timely processing of applications to avoid further delays in accessing benefits once the disenrollment period is over.

k. If a beneficiary has requested a good cause exemption, the state must provide timely notice that the good cause exemption has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

l. Comply with the screening and eligibility determination requirements in 42 CFR 435.916(f).

m. Establish beneficiary protections, including assuring that Arkansas Works beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require community engagement and employment.

n. With the assistance of other state agencies including the Arkansas Department of Workforce Services and other public and private partners, DHS will make good faith efforts to screen, identify, and connect Arkansas Works beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirements, including available non-Medicaid assistance with transportation, child care, language access services and other supports; and connect beneficiaries with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services and supports

necessary to enable them to meet and report compliance with community engagement requirements.

o. The State makes the general assurance that it is in compliance with protections for beneficiaries with disabilities under ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

p. Consider the impact of any reporting obligations on persons without access to the Internet. To the extent practicable, the State shall ensure that the availability of Medicaid services will not been diminished under this demonstration for individuals who lack access to the Internet.

q. The state will provide each beneficiary who has been disenrolled from Arkansas Works with information on how to access primary care and preventative care services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Arkansas shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.

r. The state must submit an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review. Once approved, the eligibility and enrollment

monitoring plan will be incorporated into the STCs as Attachment A. The state will provide status updates on the implementation of the eligibility and enrollment monitoring plan in the quarterly reports. Should the state wish to make additional changes to the eligibility and enrollment monitoring plan, the state should submit a revised plan to CMS for review and approval. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed and approved the revised eligibility and enrollment monitoring plan for completeness and determined that the state has addressed all of the required elements in a reasonable manner.

Plan Requirements. At a minimum, the eligibility and enrollment monitoring plan will describe the strategic approach and detailed project implementation plan, including metrics, timetables and programmatic content where applicable, for defining and addressing how the state will comply with the assurances described in these STCs, as well as the assurances listed within this STC. Where possible, metrics baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

i. Send timely and accurate notices to beneficiaries, including sufficient ability for beneficiaries to respond to notices.

ii. Assure application assistance is available to beneficiaries (in person and by phone).

iii. Assure processes are in place to accurately identify including but not limited to the following data points:

a. Number and percentage of individuals required to report each month

b. Number and percentage of beneficiaries who are exempt from the community engagement requirement.

c. Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements

d. Number and percentage of beneficiaries granted good cause exemption from reporting requirements

e. Number and percentage of beneficiaries who requested reasonable accommodations

f. Number and percentage and type of reasonable accommodations provided to beneficiaries

g. Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements

h. Number and percentage of beneficiaries disenrolled for failing to report

i. Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements

j. Number and percentage of community engagement appeal requests from beneficiaries

k. Number, percentage and type of community engagement good cause exemptions requested

l. Number, percentage and type of community engagement good cause exemptions granted

m. Number, percentage and type of reporting good cause exemptions requested

n. Number, percentage and type of reporting good cause exemptions granted

o. Number and percentage of applications made in-person, via phone, via mail and electronically.

iv. Maintain an annual renewal process, including systems to complete ex parte renewals and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

v. Maintain ability to report on and process applications in-person, via phone, via mail and electronically.

vi. Maintain compliance with coordinated agency responsibilities under 42 CFR 435.120, including the community engagement online portal under 42 CFR 435.1200(f)(2).

vii. Assure timeliness of transfers between Medicaid and other insurance programs at any determination, including application, renewal, or non-eligibility period.

viii. The state's plan to implement an outreach strategy to inform beneficiaries how to

report compliance with the community engagement requirements including how monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

XI. GENERAL REPORTING REQUIREMENTS

55. Deferral for Failure to Submit Timely Demonstration Deliverables. The state agrees that CMS may issue deferrals in the amount of $5,000,000 (federal share) per deliverable when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

    a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b. For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Extension requests that extend beyond the fiscal quarter in which the deliverable was due must include a Corrective Action Plan (CAP).

        i. CMS may decline the extension request.

        ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

56. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated

with the quarter in which the forum was held, as well as in its compiled Annual Report.

57. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

58. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to are provided; and

    c. Submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

XII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

59. Quarterly Expenditure Reports. The State must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XIII of the STCs.

60. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a. Tracking Expenditures. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 67.

    b. Cost Settlements. For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu

of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from beneficiaries that are collected by the state from beneficiaries under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:

   i. MEG 1 – "New Adult Group"

f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

Table 2 Demonstration Populations

Demonstration Year 1 (DY1)	January 1, 2014	12 months
Demonstration Year 2 (DY2)	January 1, 2015	12 months
Demonstration Year 3 (DY3)	January 1, 2016	12 months
Demonstration Year 4 (DY4)	January 1, 2017	12 months
Demonstration Year 5 (DY5)	January 1, 2018	12 months
Demonstration Year 6 (DY6)	January 1, 2019	12 months
Demonstration Year 7 (DY7)	January 1, 2020	12 months
Demonstration Year 8 (DY8)	January 1, 2021	12 months

61. Administrative Costs. Administrative costs will not be included in the budget neutrality are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

62. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements resulting from annual reconciliation) must be made within 2 years after the calendar quarter in which the State made the

expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

63. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

    a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 86, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to

the total, for a total of four eligible member months.

64. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

65. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 66:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

66. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration is state/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.

    c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

67. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for federal match.

d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement

amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes – including health care provider-related taxes – fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

68. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 69, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits

will be done using the Schedule C report from the CMS-64.

69. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 70, but not at risk for the number of beneficiaries in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

70. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 70 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 71 below.

71. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of

the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 73. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

Table 3 Per Capita Cost Estimate

MEG	TREND	DY 4-PMPM	DY 5-PMPM	DY 6-PMPM	DY 7-PMPM	DY 8-PMPM
New Adult Group	4.7%	$570.50	$597.32	$625.39	$654.79	$685.56

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group. the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from this population.

72. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

73. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

74. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis.

However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Table 4 Cap Thresholds

Year	Cumulative target definition	Percentage
DY 4	Cumulative budget neutrality limit plus:	0%
DY 5	Cumulative budget neutrality limit plus:	0%
DY 6	Cumulative budget neutrality limit plus:	0%
DY 7	Cumulative budget neutrality limit plus:	0%
DY 8	Cumulative budget neutrality limit plus:	0%

75. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

76. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through

letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

XIV. EVALUATION

77. Evaluation Design and Implementation. The State shall submit a draft evaluation design for Arkansas Works to CMS no later than 120 days after the award of the demonstration amendment. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the Health Care Independence Program. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval.

78. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a

breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

79. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the Arkansas Works Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

    a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

    b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the Arkansas Works demonstration compared to what would have happened for a comparable population in Medicaid fee-for-service.

    c. The State will compare total costs under the Arkansas Works demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utiliza-

tion and associated costs, and administrative expenses over time.

d. The State will compare changes in access and quality to associated changes in costs within the Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.

80. Evaluation Requirements. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

    The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.

81. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

    a. Research questions and hypotheses: This includes a statement of the specific research

questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate. Additional hypotheses relative to the new and revised components of the demonstration will also be included in the state's evaluation design.

i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.

ii. Premium Assistance beneficiaries will have equal or better access to preventive care services.

iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.

iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.

v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.

vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.

vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.

viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.

ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.

x. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.

xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.

xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 77 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

xiii. Incentive benefits offered to Arkansas Works beneficiaries will increase primary care utilization.

These hypotheses should be addressed in the demonstration reporting described in STC 86 and 87 with regard to progress towards the expected outcomes.

b. Data: This discussion shall include:

i. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;

ii. Method of data collection;

iii. Frequency and timing of data collection.

The following shall be considered and included as appropriate:

i. Medicaid encounters and claims data;

ii. Enrollment data; and

iii. Consumer and provider surveys

c. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. To the extent possible, the former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion

will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

f. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to

assure needed data to support the evaluation design are available.

g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.

h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.

i. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

j. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

82. Interim Evaluation Report. The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending December 31, 2021. The Interim Evaluation Report shall include the same core components as identified in STC 81 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments. The state will submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment. Also refer to Attachment C for additional information on the Interim Evaluation Report.

    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration, the research questions, hypotheses and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation

report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state will submit the final Interim Evaluation Report sixty (60) days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

83. Summative Evaluation Reports.

a. The state shall provide the summative evaluation reports described below to capture the different demonstration periods.

i. The state shall provide a Summative Evaluation Report for the Arkansas Private Option demonstration period September 27, 2013 through December 31, 2016. This Summative Evaluation Report is due July 1, 2018, i.e., eighteen months following the date by which the demonstration would have ended except for this extension.

ii. The state shall submit a draft summative evaluation report for the Arkansas Works demonstration period starting January 1, 2017 through December 31, 2021. The draft summative evaluation report must be submitted within 18 months of the end of the approved period (December 31, 2021). The summative evaluation report must include

the information in the approved evaluation design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final summative evaluation report within 60 days of receiving comments from CMS on the draft.

b. The final summative evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

b. The Summative Evaluation Report shall include the following core components:

i. Executive Summary. This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

ii. Demonstration Description. This includes a description of the demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

iii. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in

the State and any sensitivity analyses, and limitations of the study.

iv. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

v. Policy Implications. This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful demonstration strategies to be replicated in other State Medicaid programs.

vi. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

84. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 75. The State will present on its interim evaluation in conjunction with STC 79. The State will present on its summative evaluation in conjunction with STC 80.

85. Public Access. The State shall post the final documents (e.g. Quarterly Reports, Annual Reports, Final Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the State Medicaid website within 30 days of approval by CMS.

86. Additional Publications and Presentations. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

87. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate timely and fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner. Failure to cooperate with federal evaluators in a timely manner, including but not limited to entering into data use agreements covering data that the state is legally permitted to share, providing a technical point of contact, providing data dictionaries and record layouts of any data under control of the state that the state is legally permitted to share, and/or disclosing data may result in CMS requiring the state to cease drawing down federal funds until satisfactory cooperation, until the amount of

federal funds not drawn down would exceed $5,000,000.

XV. MONITORING

88. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls. Areas to be addressed include, but are not limited to:

    a. Transition and implementation activities;

    b. Stakeholder concerns;

    c. QHP operations and performance;

    d. Enrollment;

    e. Cost sharing;

    f. Quality of care;

    g. Beneficiary access,

    h. Benefit package and wrap around benefits;

    i. Audits;

    j. Lawsuits;

    k. Financial reporting and budget neutrality issues;

    l. Progress on evaluation activities and contracts;

    m. Related legislative developments in the state; and

n. Any demonstration changes or amendments the state is considering.

89. Quarterly Reports. The state must submit three Quarterly Reports and one compiled Annual Report each DY.

a. The state will submit the reports following the format established by CMS. All Quarterly Reports and associated data must be submitted through the designated electronic system(s). The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter, and the compiled Annual Report is due no later than 90 days following the end of the DY.

b. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.

c. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

d. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. The reports shall provide sufficient information for CMS to understand implementation progress and operational issues associated with the demonstra-

tion and whether there has been progress toward the goals of the demonstration.

i. Operational Updates – The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

ii. Performance Metrics – Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

e. The Annual Report must include all items included in the preceding three quarterly reports, which must be summarized to reflect the operation/activities throughout the whole DY. All items included in the quarterly report pursuant to STC 86 must be summarized to reflect the operation/activities throughout the DY. In addition, the annual report must, at should include the requirements outlined below.

i. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

ii. Total contributions, withdrawals, balances, and credits; and,

iii. Yearly unduplicated enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration) that include the member months, as required to evaluate

compliance with the budget neutrality agreement.

90. Final Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

    a. The draft report must comply with the most current guidance from CMS.

    b. The state will present to and participate in a discussion with CMS on the Close-Out report.

    c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

    d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

    e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 6.

Eligibility and Enrollment Monitoring Plan

Arkansas Works – Work and Community Engagement Amendment

Strategic Approach

Overview

Arkansas plans to test innovative and administratively efficient approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder by requiring work and community engagement as a condition of continued eligibility in the Arkansas Works program. Based on enrollment as of March 2, 2018, approximately 69,000 out of 278,734 individuals

currently enrolled in Arkansas Works will be expected to participate in monthly approved work activities. Arkansas has designed the work and community engagement requirement for Arkansas works to closely align with requirements in the Supplemental Nutrition Assistance Program (SNAP). SNAP work requirements can be reviewed in online policy through the following link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Once work requirements are fully implemented, Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, job search or community service activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be dis-enrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

External Partnering for Success

Arkansas plans to build on the innovation of the premium assistance model by partnering with insurance carriers who provide qualified health plans for Arkansas Works beneficiaries. The carriers will leverage their current care coordination and outreach activities to encourage work and assist Arkansas Works beneficiaries to engage in activities that satisfy the work and community engagement requirement as one of the steps to promoting overall healthy living. The relationship between DHS and carriers is outlined in a Memorandum of Understanding.

The Arkansas Department of Human Services (DHS) has had a long-standing partnership with the Arkansas Department of Workforce Services (DWS). Together, we have jointly administered the Temporary Assistance for Needy Families (TANF) program in Arkansas for more than a decade. Act 1705 of the 85th Arkansas General Assembly transferred the TANF block grant from DHS to DWS. Responsibilities of each agency in the operation of the program are documented through a Memorandum of Understanding that is updated annually. As part of the agreement, Arkansas DHS provides eligibility and enrollment services for the Transitional Employment Assistance (TEA) program while Arkansas DWS provides case management services to help move beneficiaries toward self-sufficiency. Arkansas DHS staff conducts eligibility interviews, explain program requirements, and authorize TEA coverage in the DHS legacy system called ANSWER. The ANSWER system automatically creates an electronic referral to Arkansas DWS staff that also has access to the ANSWER eligibility system. Arkansas DWS staff communicates with Arkansas DHS staff when changes in eligibility are needed. Act 1 of the 90th Arkansas General Assembly Second Extraordinary Session required Arkansas DHS to refer all Arkansas Works beneficiaries with income at or below 50% of the federal poverty level to Arkansas DWS for free job search and job training assistance. In compliance with this law, we expanded that partnership in January 2017 to include a referral to obtain job search assistance and training opportunities available at the Arkansas DWS for all Arkansas Works beneficiaries. Arkansas DWS has physical locations in thirty-two out of seventy-five counties and statewide services available online by accessing the following link: www.arjoblink.arkansas.gov or www.dws.arkansas.gov. Arkansas DHS

and DWS exceeded the requirement of the law by referring all recipients approved or renewed in the Arkansas Works program each month to DWS. The referral language was added to the approval and renewal notices. To track and monitor the effectiveness of the referral process, Arkansas DHS and DWS began exchanging monthly files to identify those who were referred that actually accessed services at DWS. In addition to identifying those who accessed DWS services, we also identified whether or not they were reported by employers to DWS as newly hired individuals. We obtained data through this process that demonstrates that Arkansas Works beneficiaries who had accessed services at Arkansas DWS were more likely to find work. Over the last 12 months, 347,949 Arkansas Works enrollees have received a referral to DWS. Of that number, 16,900 have accessed services at DWS. Additionally, 27% of those who accessed services at DWS have been reported by employers as new hires compared to 12% of those who did not access services at DWS. See Attachment 1 for the most recent rolling 12 month Arkansas Works – DWS referral report. We will further expand this partnership to serve Arkansas Works beneficiaries with a work or community engagement requirement. Arkansas DHS will continue to provide referrals and information about services available through the Arkansas DWS in all of our notices related to the Arkansas Works program. Attachment 2 is a sample Arkansas Works notice that contains the DWS referral language that is included in all Arkansas Works notices. Arkansas DWS will also send follow-up letters to Arkansas Works beneficiaries who have a work and community engagement requirement. A sample copy of the DWS follow up letter that is sent to Arkansas Works beneficiaries with work and community engagement requirements will be provided once

finalized. Arkansas DWS will provide career assessment, job-search assistance, and referrals for training as appropriate. The Workforce Opportunities and Innovation Act of 2014 (WIOA) placed heightened emphasis on coordination and collaboration at the Federal, State, local, and tribal levels to ensure a streamlined and coordinated service delivery system for job seekers, (from low income families including those with disabilities), and employers.

Job seekers can also explore training programs offered through the extensive Eligible Training Provider List. They can discuss education, training, and apprenticeship programs through Arkansas DWS-WIOA, their partners, and determine if they would qualify to participate in any of those opportunities. Since Arkansas Works participants are considered low income, they could be eligible for those services (Funding and slots availability, and additional requirements may apply). Arkansas Works recipients will also have access to attain Career Readiness Certifications (CRCs), create professional resumes, and other universal job services to help be effective in their job-search activities. The following screenings and assessments available in the Arkansas Workforce Integrated Network System (ARWINS) for Arkansas Works recipients:

- A basic screener to determine if the client could be eligible for UI, targeted WIOA programs, computer literacy
- Assessments that will help determine job-seeker Characteristics like Abilities, Occupational Interests, Work Values, Skills, Knowledge, and high demand occupation matches based on current education and experience levels

- Assessments that will help determine if the job-seeker has any barriers as related to Transportation, Child Care, Legal, Domestic Violence, and Homelessness

The assessments are voluntary and there is a prescribed path. The job-seeker is encouraged to take the path, but the individual will not be forced to take those assessments.

Arkansas DHS has also leveraged our current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the work and community engagement requirement. AFMC will do active outreach to educate Arkansas Works beneficiaries who need to complete work and community engagement activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their activities and to direct them to the Arkansas Department of Workforce Services, Supplemental Nutrition Assistance Program (SNAP) Employment and Training providers, or other resources as appropriate to help them comply with work requirements. Contractual requirements for work and community engagement include an outreach period 30 days prior to the beginning of work and community engagement requirements for existing Arkansas Works beneficiaries. Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about work and community engagement requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an Arkansas Works beneficiary is approved with work and community

engagement requirements. AFMC must successfully contact and educate 30% of existing Arkansas Works beneficiaries and 40% of newly approved Arkansas Works beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to our Curam eligibility system and will be receiving a daily and monthly file containing Arkansas Works beneficiaries with work and community engagement requirements and their current status related to these activities. AFMC is required to make a minimum of two attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in the Supplemental Nutrition Assistance Program (SNAP) statewide in January 2016. The Arkansas Department of Human Services has partnered with the United States Department of Agriculture Food and Nutrition Services since that time to expand the SNAP Employment and Training Program in Arkansas. Participation in SNAP Employment and Training is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities Arkansas has expanded the availability of SNAP Employment and Training from thirteen to fifty out of seventy-five counties since January 2016. In each of these counties DHS has either a contract or sub grant agreement in place with at least one SNAP Employment and Training provider with a physical location to provide employment and training services. DHS is currently in negotiations

with additional providers to add an additional fifteen counties by the end of 2018. DHS has commitments from the providers who will cover these additional counties and we are awaiting approval from the USDA Food and Nutrition Services to implement this additional expansion. Point in time data comparison in March 2018 between the SNAP program and Arkansas Works has shown that approximately twenty-two to twenty-five percent of Arkansas Works beneficiaries also receive SNAP. We plan to leverage the expanded SNAP Employment and Training program to assist individuals who are dually eligible for SNAP and Arkansas Works to meet work and community engagement requirements by referring them to SNAP Employment and Training providers as appropriate for assistance with job search and training. SNAP Employment and Training providers already attempt to reach and engage SNAP recipients. SNAP recipients who are also enrolled in Arkansas Works may satisfy work and community engagement requirements in both programs by participating in SNAP Employment and Training. A list of our current SNAP Employment and Training providers is provided as Attachment 3. A map showing the current SNAP E & T coverage is provided as Attachment 4. Proposed expanded SNAP E & T coverage by the end of 2018 is provided as Attachment 5. Dual SNAP and Arkansas Works beneficiaries will be allowed to satisfy the work and community engagement requirement for both programs by participating in and reporting in either the SNAP or the Arkansas Works program. They will not be required to comply with or report separately to both programs to maintain continued eligibility. The Arkansas Works program, SNAP, and the Transitional Employment Assistance programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted

developers for both systems, Arkansas DHS has developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff. User acceptance testing to validate this process is underway.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the work and community engagement requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Curam eligibility system that has already passed CMS readiness review standards. DHS required through contract with Curam developers that the portal is mobile device friendly and ADA compliant. The access.arkansas.gov online portal complies with 42 CFR 435.1200 f (2). Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality assurance process (See Quality Assurance and Fraud Process). Use of the portal promotes work and community engagement goals by reinforcing basic computer skills, Internet navigation, and communication via email. This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the work and commu-

nity engagement requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from work and community engagement requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS county offices. All notices provide instructions to contact the Access Arkansas Call Center or a county office for help regarding work and community engagement requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for Arkansas Works beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on our public SharePoint site at the following link: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Outcome Monitoring

Arkansas DHS will develop reports that track the following information related to the Arkansas Works program:

- Number and percentage of individuals required to report each month

- Number and percentage of beneficiaries who are exempt from the community engagement requirement
- Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements
- Number and percentage of beneficiaries granted good cause exemption from reporting requirements
- Number and percentage of beneficiaries who requested reasonable accommodations
- Number and percentage and type of reasonable accommodations provided to beneficiaries
- Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
- Number and percentage of beneficiaries disenrolled for failing to report
- Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
- Number and percentage of community engagement appeal requests from beneficiaries
- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted

- Number, percentage and type of reporting good cause exemptions requested
- Number, percentage and type of reporting good cause exemptions granted
- Number of appeals of dis-enrollments for non-compliance with community engagement
- Number of appeals for dis-enrollments for failure to comply with the reporting requirements
- Number and percentage of applications made in-person, via phone, via mail and electronically.

All of the data required to produce these reports is owned by Arkansas DHS, with the exception of the good cause exemption reports and the work and community engagement appeal requests; these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer. A database outside of the eligibility system is being developed by DHS to track and report all good cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

Implementation Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource avail-

ability assessment (See Community Resource and Supports Availability Mapping) began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018. Based on data as of March 2, 2018, there were 171,449 Arkansas Works beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Due to the number of beneficiaries impacted, Arkansas will phase in work requirements by age group. Beginning June through September 2018, beneficiaries ages 30 – 49 at or below federal poverty level will be phased in to the work requirement. 19 – 29 year olds at or below federal poverty level will be phased in during 2019 between January and April.

Based on the same data, there were 125,242 Arkansas Works beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months and number of beneficiaries affected.

Month Work Requirement Begins	Renewal Months	Approximate #of beneficiaries required to report work activities
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682
September 2018	Oct, Nov, Dec	11,146
Data date: 3/2/2018	TOTAL	38,321

The planning, testing, implementation, and monitoring timeline is provided below:

- March 15, 2018 – Mass notice will be issued to all Arkansas Works beneficiaries informing them of the change in the program and upcoming implementation of work and community engagement requirements. The notice will instruct them that no additional action is required at that time and will encourage them to provide an email address to Arkansas DHS if they have not already.
- March 30, 2018 – The Arkansas Works online portal will go live. Beneficiaries will be able to begin linking their secure online accounts and reporting exemptions.
- April 1, 2018 – New Arkansas Works beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will

become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.

- April 1– 8, 2018 – Work requirement begin months will be set for beneficiaries 30 – 49 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- April 13, 2018 – The first data file of Arkansas Works beneficiaries containing specific information regarding work and community engagement details will be provided to Arkansas DWS, the Medicaid Beneficiary Relations provider, and QHP carriers. Outreach and education will begin. Updated files will be provided weekly thereafter.
- May 8, 2018 – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in June 2018 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action.

Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and/or completion of work activities. The notice will inform them of the consequence of noncompliance.

- June 1, 2018 – Implementation of mandatory work requirements begins for individuals ages 30 – 49.
- June 8, 2018 – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in July 2018 will be mailed individually tailored notices.
- June 26, 2018 – The Post Award Forum will be held at 10:00 AM at the Hillary Rodham Clinton Children's Library and Learning Center, 4800 W. 10th Street, Little Rock, AR 72204.
- July 8, 2018 – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in August will be mailed individually tailored notices.
- August 8, 2018 – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in September 2018 will be mailed individually tailored notices.

- August 30, 2018 – Monitoring phase begins and first quarterly report will be posted to the Arkansas DHS website.
- November 1, 2018 – New Arkansas Works beneficiaries ages 19 – 29 approved beginning November 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- November 1– 8, 2018 – Work requirement phase in will be set based on renewal months for beneficiaries 19 – 29 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- November 30, 2018 – Second quarterly monitoring report will be submitted to CMS.
- December 8, 2018 – Arkansas Works beneficiaries ages 19 – 29 who are scheduled to begin the work and community engagement requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when

they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.

- January 1, 2019 – Implementation of mandatory work requirements begins for individuals ages 19 – 29.
- January 8, 2019 – Arkansas Works beneficiaries ages 19 – 29 who are scheduled to begin the work and community engagement requirement in February 2019 will be mailed individually tailored notices.
- January 30, 2019 – Third quarterly monitoring report will be submitted to CMS.
- February 8, 2019 – Arkansas Works beneficiaries ages 19 – 29 who are scheduled to begin the work and community engagement requirement in March 2019 will be mailed individually tailored notices.
- March 8, 2019 – Arkansas Works beneficiaries ages 19 – 29 who are scheduled to begin the work and community engagement requirement in April 2019 will be mailed individually tailored notices.

- April 30, 2019 – Fourth quarterly monitoring report will be submitted to CMS.

Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone. No changes are needed to the current process for applications related to the addition of the work and community engagement requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each county office can access the vendor as needed to assist individuals. Arkansas DHS also accepts applications from incarcerated individuals up to forty-five days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release. Applications received from beneficiaries who lost eligibility due to noncompliance with work and community engagement requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process will be available in a procedural desk guide developed for Medicaid eligibility caseworkers and administrative staff and will be posted online once complete.

Renewals are conducted monthly through an ex-parte process. Beneficiaries whose renewals cannot be completed ex-parte are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS. Arkansas Works beneficiaries who are subject to work and community engagement requirements will have their renewals completed by the same method as beneficiaries who are not subject to work and community engagement activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the ex-parte renewal process from occurring.

Arkansas monitors Medicaid timeliness with data and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally facilitated marketplace for individuals determined to be ineligible for Medicaid. No changes to this process are necessitated by the addition of the work and community engagement process.

Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements

Once work requirements are implemented in June of 2018, on a rolling, phased in basis, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. Link to the promulgated Medicaid eligibility manual: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Exemption from Work Requirements

Arkansas Works beneficiaries meeting one of the criteria described in the STCs will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval.

Detailed information about exemptions from work and community engagement requirements can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Allowed Work Activities and Work Activity Hour Calculations

Arkansas Works beneficiaries ages 19 – 49 who are not exempt must engage in 80 hours of monthly work and community engagement activities. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of activities as deemed appropriate by the state. Arkansas Works beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement. Detailed information about allowed work and community engagement activities can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Disenrollment for Failure to Meet Work Requirement

Beneficiaries who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three consecutive or non-consecutive months during the coverage year. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to re-enroll in Arkansas Works. Arkansas Works beneficiaries whose coverage has been terminated due to noncompliance may apply for and receive coverage in

other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with work and community engagement requirements will contain information about how to access primary and preventive care services at low or no cost at free health clinics and community health centers (See Community Resource and Supports Mapping). Closure of the Arkansas Works case will be transmitted to the InterChange Medicaid Management Information System. Termination of the QHP premium payment is automated in the InterChange system.

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and completion of work and community engagement activities. The work and community engagement portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system. Exemptions must only be re-attested to at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month. The online portal is secure, mobile device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries prepare for this requirement, Arkansas DHS and our Access Arkansas Call Center have conducted a campaign over the last several months where we encourage beneficiaries to provide an email address. We have also offered information about how to obtain free email

addresses and assistance with setting up email addresses. We have been able to collect several thousand email addresses during this effort. The portal allows beneficiaries to reset passwords through self-service. Technical assistance will also be available through our Access Arkansas Call Center for website and password issues. Beneficiaries who require assistance using the portal can receive assistance from several sources, including Arkansas DHS staff, Call Center Agents, Arkansas DWS staff, or their QHP carrier. Arkansas DHS worked with the University of Arkansas for Medical Sciences Health Literacy team to help develop language for work and community engagement notices and fliers. Similar verbiage was used on the portal for consistency and understanding at lower literacy levels. Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS county offices. Each notice and flier regarding work and community engagement direct beneficiaries who need help to contact our toll free call center or local DHS County office. The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades. Those outages when necessary are scheduled over weekends for minimal disruption. The website displays a notice each time the portal is offline for maintenance. The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their work and community engagement status for the current reporting month as well as

history for the year to date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good cause exemption. Circumstances that may lead to an approved good cause exemption are outline in the STCs and include but are not limited to a natural disaster, hospitalization or serious illness, birth or death of a family member living in the home and domestic violence. Beneficiaries who have lost coverage due to non-compliance with the work and community engagement requirement will have their cases reinstated without a new application if they are granted a good cause exemption and are otherwise eligible. Information about good cause exemptions and how to request these is provided in all work and community engagement notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly approved Arkansas Works beneficiaries who are subject to the work and community engagement requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the Arkansas Works program on any day during the month of April will be required to begin completing work activities on June 1st. Through our implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, our Medicaid Beneficiary Relations provider, and QHP carriers. This outreach effort also involves social media including Facebook and Twitter. Over the last several months, Arkansas DHS has developed several educational tools regarding work and community engagement requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the Arkansas Works program and the work and community engagement requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This Arkansas Works toolkit will be available online to the public so

that partners and beneficiaries can access the information as needed. Link to Arkansas Works education and Outreach information: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with Arkansas Works beneficiaries who have provided email addresses through an electronic message to a secure inbox. Notices content will meet all requirements in the standards, terms, and conditions reflected in the approved 1115 waiver amendment. With the exception of good cause exemption denials, all notices related to the work and community engagement requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to work and community engagement requirements have been developed and contain detailed information for beneficiaries.

Until good cause exemption functionality can be developed in our eligibility system, notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource and Supports Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each Arkansas Works qualified health plan carrier, the Arkansas Hospital Association, the University of Arkansas for Medical Sciences, and the Arkansas Department of Career Education. Input and participation is open to interested stakeholder organizations. As a result of this effort, an Arkansas Works Interactive Resource Map has been developed for users to click county by county for specific information on local resource availability. The resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations. We are also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to Arkansas Works beneficiaries in this and other ways. Arkansas DHS has lead on this project. Locations where beneficiaries and former beneficiaries can access free and reduced cost health care have also been collected and made available in this map. DHS will include information in notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the Arkansas Works information SharePoint site and will be updated quarterly and as

new information becomes available. Link to Arkansas Works Information: https://ardhs.sharepointsite.net/ARWorks/default.aspx

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM and MEQC requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence. In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of Arkansas Works beneficiaries who are subject to work and community engagement requirements to identify trends and potential anomalies that should also be reviewed for accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error prone areas. The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the Arkansas Works case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to work and community engagement requirements just as they have for other Medicaid eligibility determinations. The process will be the same regard-

less for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual Arkansas Works and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing. SNAP and Arkansas Works beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, our Medicaid Beneficiary Relations provider, and each QHP carrier. Information provided to carriers will be limited to Arkansas Works beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes contact information, work and community engagement exemption and compliance information, type of exemption, number of months of cumulative noncompliance, compliance status for the current month, and renewal month. This level of detail will allow our partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Summary

Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements. We have put a great amount of thought and effort into the policy and operational design of this program to make it as successful as possible. We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency. We appreciate the continued support and partnership from the Centers for Medicare and Medicaid Services to help us implement this program and look forward to reporting our progress as implementation continues.

ATTACHMENT B
Copayment Amounts[3]

General Service Description	Cost Sharing for Beneficiaries with Incomes >100% FPL
Behavioral Health – Inpatient	$60
Behavioral Health – Outpatient	$4
Behavioral Health – Professional	$4
Durable Medical Equipment	$4
Emergency Room Services	-
FQHC	$8
Inpatient	$60

[3] Beneficiaries with incomes above 100% FPL will also be required to pay monthly premiums of up to 2 percent of household income.

Lab and Radiology	
Skilled Nursing Facility	$20
Other	$4
Other Medical Professionals	$4
Outpatient Facility	-
Primary Care Physician	$8
Specialty Physician	$10
Pharmacy – Generics	$4
Pharmacy – Preferred Brand Drugs	$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	$8

No copayments for individuals at or below 100% FPL.

ATTACHMENT C

Preparing the Interim and Summative Evaluation Reports

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[SEAL]
STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

June 30, 2017

The Honorable Thomas E. Price, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Secretary:

On behalf of the citizens of Arkansas, I am pleased to submit an amendment to the Special Terms and Conditions for the Arkansas Works Section 1115 Medicaid demonstration. The changes proposed in this amendment were authorized by the Arkansas General Assembly during the First Extraordinary Session of 2017. In December 2016, the Centers for Medicare & Medicaid Services (CMS) approved the Arkansas Works demonstration, which implemented a new approach to health coverage for Arkansans. To date, the demonstration and its predecessor have been successful in providing continuity of coverage, smoothing the "seams" across the continuum of coverage, improving access to providers, and furthering quality improvement and delivery system reform initiatives. The changes we are seeking will build on these successes and increase the sustainability of the Arkansas Works program.

This amendment proposes four substantive changes to the Arkansas Works demonstration: (1) modify income eligibility for expansion adults to less than or equal to 100 percent of the federal poverty level (FPL) as of January 1, 2018; (2) institute work requirements

as a condition of Arkansas Works eligibility as of January 1, 2018; (3) eliminate the Arkansas Works employer-sponsored insurance (ESI) premium assistance program on December 31, 2017; and (4) implement the state's waiver of retroactive eligibility on or after July 1, 2017. Together, these amendments to the demonstration seek to test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage. The state is not requesting any changes related to budget neutrality.

I appreciate your ongoing partnership with our state and look forward to your continued support of Arkansas Works. Please do not hesitate to contact me if you have questions or need additional information.

Sincerely,

[REDACTED]
Asa Hutchinson

500 WOODLANE STREET, SUITE 250
LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345

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APPENDIX D

TITLE 42—THE PUBLIC HEALTH AND WELFARE

§ 1315. Demonstration projects

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX, or part A or D of subchapter IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of

this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

(b) Child support enforcement programs

(1) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of subchapter IV, the project—

(A) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(B) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(C) must not result in increased cost to the Federal Government under part A of such subchapter.

(2) An Indian tribe or tribal organization operating a program under section 655(f) of this title shall be considered a State for purposes of authority to conduct an experimental, pilot, or demonstration project under subsection (a) to assist in promoting the objectives of part D of subchapter IV and receiving payments under the second sentence of that subsection. The Secretary

may waive compliance with any requirements of section 655(f) of this title or regulations promulgated under that section to the extent and for the period the Secretary finds necessary for an Indian tribe or tribal organization to carry out such project. Costs of the project which would not otherwise be included as expenditures of a program operating under section 655(f) of this title and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under a tribal plan or plans approved under such section, or for the administration of such tribal plan or plans, as may be appropriate. An Indian tribe or tribal organization applying for or receiving start-up program development funding pursuant to section 309.16 of title 45, Code of Federal Regulations, shall not be considered to be an Indian tribe or tribal organization operating a program under section 655(f) of this title for purposes of this paragraph.

(c) Demonstration projects to test alternative definitions of unemployment

(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of subchapter IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 607 of this title. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test

and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the 100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 607 of this title.

(2) Notwithstanding section 602(a)(1) of this title, a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 602(a)(3) of this title. Such agreement shall provide for the payment of aid under the applicable State plan under part A of subchapter IV as though section 607 of this title had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 607 of this title (and, except as provided in paragraph (2), any related requirements and conditions under part A of subchapter IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 607 of this title and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

(d) Regulations relating to applications for or renewals of demonstration projects

(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of subchapter XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under subchapter XIX or XXI (in this subsection referred to as a "demonstration project") shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after March 23, 2010, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(B) requirements relating to—

(i) the goals of the program to be implemented or renewed under the demonstration project;

(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with subchapter XIX or XXI;

(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

(E) a process for the periodic evaluation by the Secretary of the demonstration project.

(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

(e) Extensions of State-wide comprehensive demonstration projects for which waivers granted

(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of subchapter XIX is granted under subsection (a).

(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect

to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title), of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the

Secretary's best estimate of rates of change in expenditures at the time of the extension.

(f) Application for extension of waiver project; submission; approval

An application by the chief executive officer of a State for an extension of a waiver project the State is operating under an extension under subsection (e) (in this subsection referred to as the "waiver project") shall be submitted and approved or disapproved in accordance with the following:

(1) The application for an extension of the waiver project shall be submitted to the Secretary at least 120 days prior to the expiration of the current period of the waiver project.

(2) Not later than 45 days after the date such application is received by the Secretary, the Secretary shall notify the State if the Secretary intends to review the terms and conditions of the waiver project. A failure to provide such notification shall be deemed to be an approval of the application.

(3) Not later than 45 days after the date a notification is made in accordance with paragraph (2), the Secretary shall inform the State of proposed changes in the terms and conditions of the waiver project. A failure to provide such information shall be deemed to be an approval of the application.

(4) During the 30-day period that begins on the date information described in paragraph (3) is provided to a State, the Secretary shall negotiate revised terms and conditions of the waiver project with the State.

(5)(A) Not later than 120 days after the date an application for an extension of the waiver project is submitted to the Secretary (or such later date agreed

to by the chief executive officer of the State), the Secretary shall—

(i) approve the application subject to such modifications in the terms and conditions—

(I) as have been agreed to by the Secretary and the State; or

(II) in the absence of such agreement, as are determined by the Secretary to be reasonable, consistent with the overall objectives of the waiver project, and not in violation of applicable law; or

(ii) disapprove the application.

(B) A failure by the Secretary to approve or disapprove an application submitted under this subsection in accordance with the requirements of subparagraph (A) shall be deemed to be an approval of the application subject to such modifications in the terms and conditions as have been agreed to (if any) by the Secretary and the State.

(6) An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years (5 years, in the case of a waiver described in section 1396n(h)(2) of this title).

(7) An extension of a waiver project under this subsection shall be subject to the final reporting and evaluation requirements of paragraphs (4) and (5) of subsection (e) (taking into account the extension under this subsection with respect to any timing requirements imposed under those paragraphs).

§ 1396–1. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.