State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
Maternal Life360

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program and are either pregnant with a high-risk pregnancy OR received TCM services while pregnant with a high-risk pregnancy and delivered the baby within the previous twelve (12) months.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000) ___

Areas of State in which services will be provided (§1915(g)(1) of the Act):
___ Entire State
X Only in the following geographic areas: **Areas of the state with a birthing hospital that elects to provide services**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

General client assessments will be conducted during each home visit. The frequency of visits will depend on the clients' needs and fidelity to the selected evidence based home visiting model.

Full screens for health-related social needs will be conducted at least every six months.

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- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. **DHS will audit a sample of care plans on a quarterly basis to ensure activities, contacts, services furnished, and care plan adjustments are being documented as required.**

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

An entity is eligible to be a TCM provider if it is a current Arkansas Medicaid hospital provider is licensed as a general hospital, and has an obstetrics unit.

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The TCM provider or the organization with which the TCM provider contracts to provide home-visiting services and supports must use an evidence-based home visitation model. The selected model(s) must cover home visiting services from pregnancy through at least the first two (2) years of the baby's life.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

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Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption

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placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

TOC required

200.000 LIFE360 HOMES GENERAL INFORMATION

201.000 Arkansas Medicaid Life360 HOMEs Overview 1-1-23

This provider manual (manual) offers guidance for eligible Arkansas Medicaid-enrolled hospitals to enroll as a Life360 HOME provider (Life360). The Life360 will ensure clients in target populations are connected to medical services and nonmedical supports in their communities to address their health-related social needs (HRSN) through intensive care coordination. Life360s are designed to supplement not supplant existing supports and services. Medical care will continue to be delivered and billed as it is today. There are three types of Life360s that will target populations to receive intensive care coordination services and supports specifically designed to meet those populations' unique needs (Life360 refers to all three types unless otherwise specified):

A. **Maternal Life360** will support women whose Medicaid or Medicaid-funded Qualified Health Plan (QHP) claims reflect a diagnosis code of needing supervision for high-risk pregnancy. They will be supported either through direct provision of evidence-based maternal and child home visitation or through contract with evidence-based home visitation programs.

B. **Rural Life360** will support individuals with mental illness as defined in this manual or substance use disorder (SUD) who live in rural areas of the state by providing intensive care coordination through care coordination coaches.

C. **Success Life360** will support young adults most at risk of long-term poverty and associated poor health outcomes due to prior incarceration, involvement with the foster care system, or involvement with the juvenile justice system and young adult veterans who are at high-risk of homelessness. The Success Life360 will provide intensive care coordination directly or contract with community organizations to do so.

201.100 Life360 Provider Eligibility 1-1-23

To be eligible to apply for enrollment as a Life360 provider with Arkansas Medicaid, the entity must:

A. Be a current Arkansas Medicaid hospital provider.

1. Maternal Life360 must be a birthing hospital as defined within this manual.
2. Rural Life360 must be a small rural hospital as defined within this manual.
3. Success Life360 must be an acute care hospital as defined within this manual.

203.000 APPLICATION AND APPROVAL PROCESS

203.100 Letter of Intent 1-1-23

The approval to be a Life360 happens in a four-phase process. The process is designed to ensure that eligible providers demonstrate capacity and ability to implement the program requirements outlined in this manual to achieve the goals and outcomes of the Life360 program.

Submitting all required information in the application process does not guarantee approval as a Life360. The Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) will review and determine whether approval is warranted for all applicants.

To become an approved Life360, a hospital must first submit a letter of intent (LOI) to DMS that includes:

A. The type(s) of Life360 the hospital is applying to become;

B. Hospital location, Medicaid provider ID, and proposed service area (counties to be served); and

C. Name and contact information for staff member serving as program lead.

D. For a **Maternal Life360**, the LOI must include

1. Estimated number of individuals the hospital expects to serve with home-visiting supports and services in the proposed service area and a description of how the hospital arrived at that estimate. (Indicators could include local birth rates, number of child-bearing age women in poverty, Medicaid enrollment or healthcare access, and other HRSN needs and health outcomes);
2. Number of women receiving maternity or obstetric services annually through the hospital and/or its clinics (note: “hospital” in this section means the hospital submitting the LOI);
3. The name of the evidence-based home visiting model(s) the hospital intends to use;
4. Whether the hospital will use its own staff to conduct home-visiting OR contract with an external organization to provide home-visiting; and
5. If contracting with an external organization(s), name, and contact information of organization(s).

E. For a **Rural Life360**, the LOI must include:

1. Estimated number of adults in the service area with mental illness and/or substance use disorder the hospital expects to serve and a description of how the hospital arrived at that estimate.
2. Estimated number of adults in the proposed service area likely to be eligible due to mental illness and/or substance use disorder;
3. Brief description of the mental health and substance use disorder services provided by the hospital or its clinics;
4. Names of behavioral health service providers in the proposed service area and brief description of services and/or supports they could provide to Life360 clients; and
5. Number of acute crisis unit beds the hospital currently operates or will develop.

F. For a **Success Life360**, the LOI must include:

1. Names of community service organizations currently serving the employment, educational, or training needs of the proposed service area and the estimated number served by the programs, if available;
2. Estimated number of adults in the proposed service area likely to be eligible for Success Life360;
3. Identification of community partner organizations, if using

DMS will review the LOI to determine if the hospital meets the eligibility criteria and provided all requested information. DMS reserves the right to refuse an LOI if necessary to allow time to process Life360 applications previously submitted. DMS will inform the hospital either:

A. The LOI is approved, and the hospital may move to the application phase;

B. More information is needed before approval can be made; or

C. The hospital does not meet the criteria outlined in this manual to move forward to application, for reasons including but not limited to proposing to serve too few clients or proposing a service area that is already adequately being served by other Life360s.

203.200 Application 1-1-23

Upon approval of the LOI, the hospital will submit a Life360 application within ninety (90) calendar days. The application must include:

A. A program narrative that describes:

1. How intensive care coordination will be designed and delivered according to requirements in this manual;
2. Staff and organizational experience;
3. Subcontractor experience, if applicable; and
4. Description of community partners

B. A community network assessment (template provided) (see section 203.210 for more details);

C. A copy of the hospital's most recent Community Needs Analysis (if available);

D. At least two letters of support from potential community partner organizations;

E. Plan for community outreach, education, and client communication;

F. How services will supplement, not supplant, services already provided in the community;

G. Description of proposed referral network and signed agreements with community partner organization, pending approval of the Life360 application (See section 203.210);

H. Plan for monitoring client milestones and goals, collecting data on client outcomes, and monitoring other quality improvement measures identified by DMS; and

I. Startup and first-year program budget and narrative justification

J. Proposed screening tool(s) and a description of the screening processes

DMS will review the hospital's application and materials upon receipt of a complete application package and will respond within a specified timeframe in writing to approve, deny, or request additional information. If additional information is needed, the applicant hospital will have thirty (30) calendar days to provide the additional information. DMS will review and approve or deny any application within a specified timeframe.

The following sections 203.210-203.230 provide criteria for each application requirement.

203.210 Community Network Assessment 1-1-23

As part of the application, the hospital will:

A. Complete an assessment of the service area population demographics and a community resource inventory to determine the available community resources and gaps. That inventory should include community medical providers, community service organizations, and social service providers ~~that~~to whom the Life360 can refer clients to access appropriate services and supports.

1. Once a hospital becomes a Life360, the hospital will update this information annually as a requirement of the annual Life360 HOME agreement and will be responsible for ongoing program and resource development.

2. Access to medical services and availability of non-medical supports should be described (i.e., number of primary care/specialists, number of organizations providing supports and type of supports, data on wait times or distance to care, if available).

B. Identify providers and others in the service area who can serve as a referral network to refer someone for Life360 services.

1. Referrals can be from a diverse array of health and social service organizations, medical providers, and non-medical supports in the community through formal and informal agreements and based on the target population served.

2. Determine which organizations will require formal community partner agreements, particularly an entity that would share personal client information, to ensure health information is protected. Applicant hospital will submit those agreements as part of the application, and DMS will review them as part of the application and/or readiness review process.

203.220 Referral Network Outreach 1-1-23

After application approval, the selected applicant and its partners will be responsible for community outreach to ensure entities that can make referrals are aware of Life360 services and the referral process, for general outreach and awareness activities directed at the target population as well as key community groups that would have direct contact with and are trusted by the Life360 target population.

203.230 Community Partner Organization Criteria 1-1-23

To be eligible to contract with a Life360 hospital to provide intensive care coordination services, an organization must meet the qualifications for the relevant Life360 type, as described below. Hospitals are responsible for confirming the organization has a tax identification number, is in good standing with relevant government entities, and other due diligence of partner organizations. Community partner organizations will work with the Life360s to conduct outreach to ensure providers and local entities are aware that they can refer clients for services.

A. **Maternal Life360** - The Life360 or the organization with which the Life360 contracts to provide home-visiting services and supports must use an evidence-based maternal and child home visitation model. The selected model(s) must cover home visiting services from pregnancy through at least the first two (2) years of the baby's life.

B. **Success Life360** - The organization with which the Life360 contracts must be experienced in working with young adults most at risk of long-term poverty to build their skills to be physically, socially, and emotionally healthy in order to live in and contribute to their communities.

This section criteria does **not** apply to **Rural Life360.** Hospitals will directly provide intensive care coordination to the target population. Providers of behavioral health services will be engaged by the hospital as key partners for referrals and delivery of services.

203.300 Startup 1-1-23

Once an application is approved, the selected applicant must sign a startup agreement before DMS will release the first round of startup funding. For information about the amount of startup funding allowed, see the rate sheet. After the agreement is signed the selected applicant will be in the startup phase, and DMS will release the first installment of startup funds. The hospital must follow the startup plan and budget outlined in the approved application. Hospitals may not

receive more than one package of startup funding for more than one application of the same type of Life360s.

For both **Maternal Life360s** and **Rural Life360s**, startup funds will be:

A. Provided in two initial payments to be used for the cost of starting the program.

1. The first upon DMS approval of the application
2. The second after successful completion of the readiness review

B. Based on the approved program budget and contained in the startup agreement.

C. Allowed to cover the cost of staff, equipment, and supports identified in the selected applicant's startup budget or otherwise approved by DMS. Expenditures will be subject to audit.

For **Success Life360s**, startup funds will be:

A. Provided in three initial payments to be used for the cost of starting up the program.

1. The first upon DMS approval of the application and signed startup agreement
2. The second after successful completion of the readiness review
3. The third payment will be released by DMS in accordance with the selected applicant's approved startup agreement

B. Based on the approved annual program budget contained in the startup agreement.

C. Allowed to cover the cost of staff, equipment, and supports identified in the applicant's startup plan budget or other uses approved by DMS. Expenditures will be subject to audit.

Each selected applicant must complete the startup phase within the timeframe specified in its startup plan, not to exceed one-hundred-eighty (180) days from the receipt of startup funds, or funds may be subject to recoupment. During the startup phase, DMS and the hospital working to become a Life360 will meet monthly to assess progress toward readiness review. DMS will schedule readiness review at the end of the startup phase.

203.400 Readiness Review 1-1-23

After approval of the application and completion of the startup phase, a readiness review will be conducted by DMS or its contractor to determine the selected applicant's readiness to fully implement the Life360 program. Readiness review will include an onsite visit to each location. Each selected applicant will demonstrate that it is operationally ready to fulfill all Life360 requirements including:

A. Having the ability to submit enrollment requests to DHS and accept results of client eligibility verification

B. Having the ability to report required data to DMS in the format requested

C. Having an HRSN screening tool and the necessary staff training to administer it, a platform for capturing results, and a process for linking clients to resources

D. Providing ~~A~~any other client assessment tools to be used by the program

E. Having a person-centered action plan (PCAP) template and plan for updating the PCAP regularly, at a minimum annually

F. Having adequate program staff and appropriate staff training

G. Having ~~F~~fully executed community partner agreements

H. Having a referral network, agreements, and a process for accepting and transferring protected health information

I. Demonstrating that the Life360 and its partners have a communication, outreach, and referral plan

J. Having fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer

K. Having an operational acute crisis bed(s), for Rural Life360 only

DMS will schedule the readiness review within five (5) business days after being notified by the selected applicant that it is ready to complete the review. DMS will complete readiness review and provide the outcome of the review in writing within a specified timeframe of the onsite visit. Following the completion of the readiness review, DMS will either:

A. Enroll the hospital as a Life360 provider, enter into the Life360 HOME agreement, and release the second installment of startup funds;

B. Release all or a portion of the second installment of startup funds and provide in writing a list of deficiencies and the timeframe by which the deficiencies must be addressed for the hospital to demonstrate readiness; or

C. Deny enrollment as a Life360 for failure to successfully complete readiness review.

203.500 Life360 HOME Agreement 1-1-23

To enroll in the Life360 program, applicants that successfully complete the application process and readiness review will provide their tax ID number and enter into the Life360 HOME agreement. The agreement will outline required program obligations and legal requirements pertaining to the Life360 scope of work. Through execution of the agreement, providers agree to adhere to all requirements in this manual and all applicable federal regulations and state statutes.

203.700 Electronic Signatures 1-1-23

Medicaid will accept electronic signatures, provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM REQUIREMENTS

210.100 Client Eligibility 1-1-23

Life360 client participation is voluntary. An individual is not required or entitled to receive services from a Life360 as a condition of Medicaid eligibility. To be screened for HRSN and/or Life360 eligibility, clients must live in the service area served by the Life360. Residence can be determined by the person's geographic residence, shelter residence or other temporary residence, such as a health facility. If experiencing homelessness, residence may be established by the last documented residence or shelter, work history/place of employment, or child's school/childcare enrollment.

A client may be enrolled in only one Life360 program at any time.

A client who moves from one Life360 service area to another may continue receiving services through the new Life360 if the new Life360 type is the same as the previous (e.g., Maternal to Maternal). If the Life360 type in the new service area is different, the client may receive services from the new Life360 only if the client qualifies for those services.

Additional eligibility requirements by Life360 type include:

A. A woman is eligible for **Maternal Life360** intensive care coordination supports if she:

1. Is enrolled in Arkansas Medicaid or was enrolled in Arkansas Medicaid when she began receiving Maternal Life360 services and is either pregnant with a high-risk pregnancy (a diagnosis of needing supervision for high-risk pregnancy. High-risk pregnancy must be verified through a completed referral form from the client's physician that includes the most current clinical note.) OR

2. If enrolled in ARHOME at any point during enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twenty-four (24) months

   OR If enrolled in a Medicaid program that is not ARHOME for the full duration of enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twelve (12) months.

3. Is not currently receiving state- or federally funded home visiting services through a provider whose services cover pregnancy or the first two (2) years of a baby's life.

B. An individual who needs assistance confirming a high-risk pregnancy diagnosis will be eligible for assistance in connecting with medical services until the need for supervision for high-risk pregnancy is confirmed. The Life360 HOME will not receive per member per month (PMPM) funding until the woman's pregnancy and eligibility for the program are confirmed.

C. All adults living in the **Rural Life360** service area are eligible for HRSN screening and referrals to needed community supports. To be eligible for intensive care coordination, the individual ~~also~~ must:

1. Be enrolled in ARHOME (through a qualified health plan [QHP] or Medicaid fee-for-service [FFS];

2. Have a mental health and/or substance use disorder diagnosis;

3. Not be enrolled in the Provider-led Arkansas Shared Services Entity (PASSE) program.

D. An individual is eligible for **Success Life360** intensive care coordination and supports if the person:

1. Is enrolled in ARHOME (through a QHP or Medicaid FFS);

2. Is at risk of poor health due to poverty, meaning under one hundred thirty eight percent (138%) Federal poverty level;

3. Is not enrolled in the Provider-led Arkansas Shared Services Entity (PASSE) program; and

4. Meets the criteria for at least one of the following categories:

   a. Is between nineteen (19) and twenty-four (24) years of age and has been previously placed under the supervision of the DHS Division of Youth Services as verified by DHS.

   b Is between nineteen (19) and twenty-four (24) years of age and has been previously placed under the supervision of the Arkansas Department of Corrections, as verified by the Arkansas Department of Corrections or DHS.

   c Is between nineteen (19) and twenty-seven (27) years of age and has been previously placed under the supervision of the DHS Division of Children and Family Services~~;~~, as verified by DHS.

   d Is between nineteen (19) and thirty (30) years of age and is a veteran verified

by DD214 Certificate or Release of Discharge from Active Duty.

210.200 General Program Requirements 1-1-23

All Life360s must:

A. Submit an annual budget and budget narrative, including staff, to DMS for approval.

B. Provide an explanation of how the Life360 will meet targeted number of clients to be served, if ~~you~~it failed to meet expected numbers in the previous year

C. Provide service projections (e.g., the number of clients the Life360 expects to serve, the number of visits anticipated for each client, the number of individuals screened, etc.)

D. Provide all other required supports specified in the Life360 HOME agreement.

E. Provide or contract to provide supports that demonstrate cultural competency and are provided in the languages frequently spoken by the targeted population as identified in the community assessment.

F. Comply with all reporting requirements and deadlines specified in the Life360 HOME agreement and any additional reporting requirements required by the Centers for Medicare and Medicaid Services and/or the Arkansas Legislature.

G. Maintain fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer.

H. Provide a monthly expenditure report. The expenditure report must provide all expenditures compared against budgeted categories. Maternal Life360s will provide all program expenditures, but only the expenditures for startup and transportation funding will be compared against budgeted categories. For **Rural** and **Success Life360s**, the monthly expenditure report also must include an estimate of funds the Life360 anticipates will be unspent by the end of the program year. DHS may adjust the annual budget in the middle of the year, if necessary, to bring the Life360's operations in line with actual spending patterns.

I. For **Rural** and **Success Life360s**, unspent funds will be applied to the Life360's budget for the following year, and DMS will reduce new funds provided by the amount of unspent funds the Life360 is carrying forward. Life360s with unspent funds cannot submit a budget in the subsequent year that exceeds the budget for the year in which the unspent funds accumulated. DMS may make an exception for circumstances that were unique to a particular program year.

210.300 Service Area Criteria 1-1-23

The Life360 may define its service area. The service area must ~~to~~ include ~~only~~ the county in which the Life360 is located and may include one or more counties contiguous to that county or to each other. As part of the application process, DHS will assess whether the applicant hospital can serve the selected service area adequately or it needs to be adjusted.

Rural Life360 service areas may include counties containing a Metropolitan Statistical Area (MSA), but the Life360 must be established to primarily serve the hospital's patient population and non-MSA counties. DHS will assess whether the applicant hospital's selected service area adequately serves rural populations.

Success Life360 service areas must include the county in which the hospital is located and the county in which the community partner organization is located. If the hospital and the community partner organization are in separate counties, the counties must adjoin.

210.400 Required Maternal Life360 Activities 1-1-23

The **Maternal Life360** will provide directly or through its selected community partner organization(s) the following services and supports for their clients:

A. Request from DHS enrollment and eligibility verification for individuals referred or identified for home-visiting supports, including assisting individuals with the diagnosis of need for supervision for high-risk pregnancy.

B Obtain a signed consent form from clients to participate in the program and to authorize the Life360 HOME to share their personal information with DHS, partner organizations, relevant community service providers, and relevant health care providers.

C Administer screenings that includes HRSN screenings (upon client enrollment in Life360 and every six (6) months during program participation) as well as other required health screenings for all eligible clients that will help inform the supports delivered to improve outcomes in:

1. Maternal Health
2. Child Health
3. Family Economic Self-Sufficiency
4. Positive Parenting Practices

D Provide home visitation services with fidelity to an evidence-based home visiting model and linkages to community resources and supports. Home visiting may be provided directly by the hospital or through contract with evidence-based home visitation program.

E. Assist with any needs for coordination of medical services including support identifying and connecting both the client and her baby to a PCP or OB/GYN and any other needed medical and behavioral health providers or culturally relevant supports.

F. Document home-visiting services provided.

G. Disenroll individuals who have asked to stop receiving services or who are uncooperative with receiving services after three consecutive attempts to schedule a visit. Disenrolled clients can re-enroll at their request within their pregnancy or, for ARHOME enrollees, within the first twenty-four (24) months after delivery and for participants in any other Medicaid aid category, within the first twelve (12) months after delivery.

H. Ensure coordination with other home visiting programs as applicable.

210.500 Required Rural Life360 Care Coordination Activities 1-1-23

The **Rural Life360** will provide the following community screening and referral supports to the general population and care coordination to identified clients.

A. Create a plan and implement the plan to screen anyone in the community for HRSN needs and provide support for community providers to complete and submit HRSN screens for the people they serve.

B. Connect individuals whose HRSN screen identifies an HRSN need to local medical and non-medical resources, including food, housing, and transportation.

C. Accept referrals for care coordination supports for eligible clients from health care providers treating individuals with mental illness or substance use disorder.

The **Rural Life360** will provide the following healthcare capacity building activities:

A. Develop and operate an acute crisis unit that meets the requirements of 218.400 of the Arkansas Medicaid Hospital Provider Manual or a psychiatric care unit that meets the requirements specified in the Rules for Hospitals and Related Institutions in Arkansas. The ACU or psychiatric unit must serve individuals in need of mental health or substance use crisis services in the Rural Life360 hospital. The Rural Life360 hospital must begin acute crisis unit or psychiatric services within the timeframe approved by DMS.

The **Rural Life360** will provide the following care coordination supports:

A. Request from DHS enrollment and eligibility verification for individuals referred or identified for intensive care coordination supports.

B. Obtain a signed consent form from clients to participate in the program and to authorize the Life360 HOME to share their personal information with DHS, partner organization, relevant community service providers, and relevant health care providers.

C. Provide intensive care coordination and coaching supports for enrolled clients. Intensive care coordination and coaching includes:

1. Collecting or completing an HRSN screen upon client enrollment in Life360 and every six (6) months during program participation
2. Conducting an in-depth personal interview related to the health-related social needs identified in the screening and the barriers to resolving health-related social needs. The Rural Life360 is responsible for developing the interview tool to be used, the implementation process and the staff training process for engaging clients.
3. Developing and maintaining a person-centered action plan (PCAP) for each client that includes:
    a. The client's goals and preferences for addressing needs. Goals must include accessing a PCP and all needed medical providers and services. Goals also may include mental and emotional wellness, financial goals, applying for or completing workforce training or education programs, obtaining or maintaining employment, and obtaining or sustaining safe housing.
    b. Results of the HRSN screen and personal interview including strengths and relevant personal history, for example, criminal justice involvement.
    c. Plan for overcoming barriers for accessing services and for avoidance of non-emergency ED visits.
    d. Unmet needs for medical services and non-medical community supports and a plan for meeting those needs.
4. Working directly with clients and their families to improve their skills to be healthy physically, socially, emotionally and to thrive in their communities. Follow up supports may include the following activities as specified in the PCAP:
    a. Engaging clients in promoting their own health
    b. Coordinating with external medical and non-medical providers to connect clients with needed health services and community supports
    c. Assisting clients with applying for services including scheduling and completing assessments for entry into the PASSE program, if needed
    d. Assisting clients in obtaining services that reduce preventable utilization of emergency departments and inpatient hospital settings
    e. Increasing client engagement in educational and employment opportunities and other supports that reduce the risk of poverty
    f. Transporting clients to non-medical appointments. Life360 funds cannot be used for costs incurred transporting a client or assisting with transportation of a client to a job interview

5. Providing supports through any of the following:
   a. Home visits in such frequency as is necessary to assist the client meet his/her documented PCAP goals
   b. Office visits
   c. Video-supported visits
   d. Telephone or text message contacts in conjunction with in-person visits
6. Documenting client's progress toward meeting goals established on person-centered action plan, including:
   a. Weekly update of client and staff activities
   b. Gaps in available community services
   c. Responsiveness from client
   d. Any completed or newly identified goals or unmet needs

210.600 Required Success Life360 Care Coordination Activities **1-1-23**

The **Success Life360** will work with its partner organization to provide the following services:

A. Request from DHS enrollment and eligibility verification for individuals referred or identified for intensive care coordination and supports.

B. Obtain a signed consent form from client to participate in the program and to authorize the Life360 HOME to share the client's personal information with DHS, partner organizations, relevant community service providers, and relevant healthcare providers.

C. Provide intensive care coordination and coaching supports for clients to include:
   1. Collecting or completing a HRSN screen (upon client enrollment in Life360 and every six (6) months during program participation)
   2. Conducting an in-depth personal interview related to HRSN identified in the screening and the barriers to addressing those needs. The Life360 is responsible for developing the interview tool to be used, the implementation process and the staff training process for engaging clients
   3. Developing and maintaining a PCAP for each client that includes:
      a. Client goals and preferences for addressing needs. Goals should address:
         i. Obtaining a primary care physician and addressing unmet medical needs
         ii. Mental and emotional wellness
         iii. Financial needs, including applying for or completing workforce training or education programs
         iv. Obtaining or maintaining employment, and
         v. Obtaining or sustaining safe housing
      b. Identified HRSN needs and personal interview results, including strengths and personal history if applicable, such as criminal justice involvement
      c. Plan for overcoming barriers for accessing services and avoidance of non-emergent emergency department visits
      d. Unmet needs for non-medical community supports and a plan for meeting those needs
   4. Working directly with clients and their families to improve their skills to be healthy physically, socially, emotionally, and to thrive in their communities. Services may include the following activities as specified in the PCAP:
      a. Engaging clients in promoting their own health

b. Coordinating with external medical and non-medical providers to connect clients with needed health services and community supports

c. Assisting clients in obtaining services that reduce preventable utilization of emergency departments and inpatient hospital settings

d. Strengthening client life skills and implement plan to maximize participation in education, employment training and other supports that reduce the risk of poverty

e. Transporting clients to non-medical appointments. Life360 funds cannot be used for costs transporting a client or assisting with transportation of a client to a job interview.

5. Providing supports through:

a. home or community visits

b. office visits including career center

c. video-supported visits

d. telephone or text message contacts, though not exclusively so

6. Documenting client's progress toward meeting goals established in the PCAP, including:

a. Weekly update of client and staff activities

b. Gaps in available community services

c. Responsiveness from client

d. Any completed or newly identified goals or unmet needs

210.700 Program Funding **1-1-23**

After the startup phase and successful completion of readiness review, Maternal Life360 will receive the following payments:

A. A PMPM: global payment will be made to a Maternal Life360 to cover the costs of all home visiting services necessary to implement home visiting model fidelity and administrative costs of operating the program (staff recruitment and training, data collection and reporting, financial management, etc.). The global payment will be actuarially sound and made to each Maternal Life360 on a per member per month (PMPM) basis. The global capitation payment amount is determined by Arkansas Medicaid.

B. Transportation: An annual amount specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding may be used for transportation costs incurred during home visits to clients, to transport clients to non-medical appointments (excluding transportation to job interviews), or to obtain other HRSN-related supports. Allowable uses of this funding include:

1. Gasoline or mileage for the Life360s travel

2. Bus travel, car rental, and taxi or other driver service for non-medical appointments for clients necessary to meeting the client's documented HRSN needs (excluding transportation to job interviews)

3. Staff time for operating a vehicle for transporting clients to and from non-medical appointments.

C. The **Maternal Life360** will receive a prorated PMPM for clients beginning upon client enrollment in in the Maternal Life360. Payments will be prorated for the number of days in the month from the client enrollment date.

Rural Life360s will receive three (3) additional types of payments following startup costs for:

A. Transportation: An annual amount specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding may be used for transportation costs incurred during home visits to clients, to transport clients to non-medical appointments (excluding transportation to job interviews), or to obtain other HRSN-related supports. Medicaid clients should utilize non-emergency transportation services for medical appointments. Allowable uses of this transportation funding include:

1. Gasoline and mileage for the Life360s travel

2. Bus travel, car rental, and taxi or other driver service for client transportation to non-medical appointments necessary to meeting the client's documented HRSN needs (excluding transportation to job interviews).

B. Emergency Equipment and Training: In a monthly amount based on the approved annual program budget and specified in the Life360 HOME agreement. DMS will divide the annual amount by twelve (12) and pay the Life360 monthly up to the annual allotment amount. The funding may be used for costs related to improving emergency medical services in the rural communities that the Life360 serves, including enhanced equipment and staff training, and to support improvements in equipment necessary for the delivery of medical services through telemedicine. An accounting of these funds must be provided as part of the monthly expenditure reports.

C. Intensive Care Coordination: In a monthly amount based on the approved program budget and specified in the Life360 HOME agreement. DMS will pay an all-inclusive flat rate monthly to pay for assisting clients through intensive care coordination, one-on-one engagement, community HRSN screening and referrals, the cost of supervisors, and other program costs. The fee includes both direct program costs and indirect costs as outlined in the program payment section. Allowable uses include staff, equipment, and supports identified in startup plan and budget, and other uses approved by DMS. Time-limited expenses to enable a client to access services or supports to meet an identified HRSN also are allowable program costs. Refer to the glossary under HRSN reimbursable costs. The all-inclusive rate will include an amount up to 20 percent of the direct staff costs for indirect costs associated with managing the program.

D. Acute Care Unit Observation and Stabilization Staff: In a monthly amount based on the approved program budget and specified in the Life360 HOME agreement. DMS will divide the annual amount used for costs related to maintaining continuous clinical staff in the acute care unit into monthly amounts. This funding is intended to assist the hospital with paying for the ACU to be staffed and available even when patient services are not immediately needed.

Success Life360 will receive three additional types of payments following the startup payments:

A. Technology: An annual amount based on the approved annual program budget and specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding may be used for technology costs incurred to support data-sharing with partner organizations and providers that serve clients, including equipment, infrastructure, and technology and data services.

B. Intensive Care Coordination: In an annual amount based on the approved program budget and specified in the Life360 HOME agreement. DMS will pay an all-inclusive flat rate monthly to pay for assisting clients through intensive care coordination, one-on-one engagement, the cost of supervisors, and other program costs. The fee includes both direct program costs and indirect costs as outlined in the program payment section (See 230.000, Payment Details). Allowable uses include staff, equipment, and supports identified in the startup plan and budget and other uses approved by DMS. Time-limited expenses to enable a client to access services or supports to meet an identified HRSN

also are allowable program costs. Refer to the glossary under HRSN reimbursable costs. The all-inclusive rate will include an amount up to 20 percent (20%) of the direct staff costs for indirect costs associated with managing the program.

C. Success Payments: DHS will award a success payment to the Life360 for each enrolled client who achieves the following goal(s):

1. Clients who were formerly in the custody of the DHS Division of Youth Services or the Arkansas Department of Corrections remain out of the judicial system (no arrests or criminal charges) and out of incarceration for twelve (12) consecutive months after enrollment in the Life360.
2. Attains an educational diploma, certificate, or degree, including a General Educational Development certificate, high school diploma, associate degree, certificate program through an accredited institution of higher education, or completes a workforce training, trade, or other work certification program after enrollment in the Life360.
3. Achieves full-time employment and maintains it for twelve (12) consecutive months after enrollment in the Life360.
4. Maintains full-time employment for twelve (12) consecutive months after enrollment in the Life360.
5. Clients who have a diagnosis of SUD and maintain sobriety for twelve (12) consecutive months as confirmed by a treatment program, rehabilitation program, sponsor, or support group leader after enrollment in the Life360.

Success Life360s will inform DHS of any clients who have achieved any of these milestones. DHS will review and determine whether the Life360 may receive one (1) or multiple success payments for a single client who achieves in more than one (1) category. The amount of the payments will be established annually and published in the Life360 HOME agreement. Life360s may provide enrolled clients nominal incentives valued at no more than two-hundred and fifty dollars ($250) annually for achieving milestones or goals.

Maternal, Rural and Success Life360 expenditures will be subject to audit.

210.8900 Acceptable Performance and Performance Measures 1-1-23

Life360's supports must meet acceptable performance, which will be determined based on whether it has been able to fulfill the program requirements and performance measures outlined in the Life360 HOME agreement with DMS, including:

A. Serving the targeted number of clients, number of visits, number of individuals screened, as specified in the Life360 HOME agreement

B. Meeting all reporting requirements specified in the Life360 HOME agreement in the specified timelines

C. Demonstrating client success as evidenced by meeting annual targets outlined in the Life360 provider agreement.

Life360 performance measures are proposed and subject to change based on the final evaluation and monitoring plan approved by CMS.

DHS will ensure that Life360s meet acceptable performance and that action is taken to address any identified non-compliance with Life360 funding parameters. If DHS determines that a Life360 has failed to demonstrate appropriate performance, including enrolling an insufficient number of clients, DHS may impose corrective actions that could include:

A. A corrective action plan

B. Caps on funding

C. Recoupment of funds

D. Discontinuation of Life360 funding

DHS also may impose corrective actions for a Life360 if it determines the Life360 is out of compliance with requirements included in the Life360 HOME agreement and/or policy letters or guidance set forth by DHS or CMS ARHOME 1115 Demonstration Special Terms & Conditions or the CMS 1915(b) Standard Terms & Conditions. Prior to initiating any corrective action on a provider, DHS shall provide the provider notice and an opportunity to comment regarding the identified area of non-compliance.

220.000 DELIVERY OF SERVICES

220.100 Life360 Client Engagement 1-1-23

This manual is not exhaustive of what will need to be in place to ensure consistency and integrity of services provided to Life360 clients. Programs are expected to establish policies and procedures prior to implementation to ensure successful client engagement, safety, and adherence to all applicable laws and/or requirements in serving clients. To that end, Life360s will be responsible for ensuring the following guidance for services as well as any requirements contained in the Life360 HOME agreement, or in this manual pertaining to provision of services, are incorporated.

220.200 Consent 1-1-23

Each client who is confirmed eligible by the Life360 will complete a consent form prior to intensive care coordination services beginning. Clients must be informed of relevant program policies and procedures relative to their participation in the program including client and staff safety, confidentiality, how long/frequent services are available, program expectations, and that services are voluntary. This program communication must be approved by DHS.

The program must notify clients at the time of consent if there will be a delay in starting services for any reason (i.e., program at capacity, facility, or staff issue), inform the client of the wait time, and the referral partner, if applicable. The Life360 should connect waiting clients with other supports/services until Life360 services may begin. Life360s will not receive a PMPM payment for clients awaiting Life360 services. The Life360 must notify its referral network when clients cannot be assigned to a care coordinator due to capacity limitations or other factors. The Life360 must notify DHS if the program is delaying services for new clients or suspending services to existing clients. The notification must be made within five days of denying or suspending services to eligible clients.

220.300 Duration of Services 1-1-23

The total length of time in which clients can receive intensive care coordination services is as follows:

A. **Maternal Life360** - Services begin during pregnancy through home-visiting and continue up to two years after birth of the baby for clients enrolled in a QHP through ARHOME and one year for clients enrolled in any other Medicaid category of assistance and based upon continued need of home-visiting support.

B. **Rural Life360** - Services can be provided by care coordination coaches for up to twenty-four (24) months if the individual is actively working towards his or her goals and the individual remains eligible for the ARHOME program. DMS may extend the amount of time someone is eligible for a Rural Life360 based on a review of goals and progress toward

those goals. If an enrolled client moves to another Medicaid aid category, the client will be disenrolled from the Rural Life360 program.

C. **Success Life360** – Services are based upon PCAP goals, and obtainment of goals is expected to be achieved in twenty-four (24) months or less. If an enrolled client moves to another Medicaid aid category, the client will be disenrolled from the Success Life360 program.

220.400 Person-Centered Action Plan (PCAP) 1-1-23

Rural Life360 and **Success Life360** clients will develop an individualized person-centered action plan (PCAP) facilitated by their care coordination coach or community partner organization to address health needs and HRSN. The PCAP will be updated regularly to reflect goals met, new circumstances or needs, annually at a minimum. The PCAP must describe the client's strengths, preferences, and HRSN as identified by the HRSN screen as well as needs for linkage with medical providers. The plan must include short-term (less than 6 months) goals, a crisis plan, and longer-term goals (more than 6 months). Each PCAP must include goals in areas identified through screening and ongoing interaction with the client, including but not limited to:

A. Safe housing including utilities, if necessary

B. Food security and nutrition

C. Employment and/or education

D. Financial stability and any needed social services

E. Health and emotional wellness

F. Establishing a relationship with a PCP and all needed healthcare providers for preventative care (and to avoid non-emergent emergency department visits)

G. Criminal justice involvement, if applicable

H. Transportation

Maternal Life360 will implement the approaches of the evidence-based model selected and/or processes set by the program that utilize best practices and tools for quality and effectiveness of home visits and to document observations and assessments of maternal/child health and any other family outcomes included. Therefore, a separate PCAP will not be required.

220.500 ~~SDOH~~HRSN Screening and Other Assessments 1-1-23

A HRSN screening will be conducted with every Life360 client as part of the initial eligibility determination within fifteen (15) calendar days of referral and every six (6) months during program participation. This screening also starts the process to identify areas for intensive care coordination. The screening should be done in a manner that is consistent, or asks the same questions across individual clients, is accessible or engaging for the client, and is coordinated with any additional screening and assessment that may part of the program. The screening tool must address the following core elements.

A. Housing instability

B. Food insecurity

C. Utility needs

D. Interpersonal safety

E. Transportation needs

F. Financial strain

G. Employment

H. Family and community support

I. Education

J. Physical activity

K. Substance use

L. Mental health

M. Disabilities

DHS will review the screening tool(s) during the application process. DHS may provide feedback on the tools and require revisions to ensure alignment with program goals. If a Life360 changes its HRSN screening tool, it must submit its new tool before making the change to DHS for approval. Life360s may only change screening tools at the beginning of a calendar year.

220.600 Intensive Care Coordination 1-1-23

Care coordination will be conducted by:

A. Home-visiting staff who meet the qualifications of the evidence-based home-visiting model the Life360 implements for the Maternal Life360 program

B. Care coordination coaches for the Rural Life360 program who are vetted and approved by the hospital. Individuals may be a peer or someone with lived experience, and/or an individual familiar with local resources.

C. Staff or volunteers vetted and approved by community partner organizations for Success Life360 program

The individuals in these roles are expected to form a trusting relationship with the client and serve as a significant source of support to the client. Individuals in these roles will meet with the client as frequently as needed and provide life skills development and training as appropriate and directly connects the client with medical, educational, and social services and supports needed to meet the client's goals. They also will actively assist the client in obtaining services and supports, communicating with providers about referrals and outcomes of services and supports, encourage and motivate the client to set and attain goals and meet milestones, and provide advocacy as needed.

220.700 Frequency and Duration 1-1-23

Frequency of interaction, or how much time lapses in between, is to be determined based on the selected program model or evidence-based, home-visiting model. Meetings/visits with client should be based on the client's needs and occur consistently. The duration of client meetings/visits (e.g., one (1) hour) should be sufficient to address client needs, follow any program model guidance or policies, and be flexible enough to accommodate the client's work schedule/life circumstances.

220.800 Setting and Location 1-1-23

Intensive care coordination may be delivered in the client's home, or in the community partner organization facility, medical clinic, behavioral health clinic, or hospital settings. For some clients, services may occur in a shelter setting or educational/job training settings. Video--supported

~~telehealth~~ visits also may be appropriate, particularly for **Rural Life360** or clients being served in remote areas or for clients experiencing contagious illness.

220.900 Client Termination of Services 1-1-23

A client may terminate services at any time by informing the DHS enrollment broker or Life360 provider if they no longer wish to participate. Clients may be allowed to re-enroll at any time if they remain eligible for the program.

Life360s must disenroll clients for the following reasons:

A. Client moved outside of the program's service area

B. Client is living in an institution for more than thirty (30) days

C. Client is incarcerated or in jail

D. Client has died

E. Client has an illness that does not allow for continued participation

F. Client continues to display disruptive or unsafe behavior that threatens staff safety

G. Client is no longer eligible for the program

H. Client stops participating in services for thirty (30) days and is non-responsive to Life360 contact efforts

I. Other reasons approved by DMS

If the reason for disenrollment is failure to participate in the program, the Life360 must attempt to contact the client at least three times before moving forward with disenrollment. The Life360 must provide notification of disenrollment to DHS for E, F, H, and I that provides the reason for the disenrollment and supporting information.

Life360s may not terminate services because a client is experiencing homelessness or housing instability. The Life360 or its community partner organization should work with the client to identify resources to move toward stable housing as well as arrange other safe settings for meetings where client confidentiality can be maintained. Clients who enter a residential treatment program or who may have an illness for a brief period (60 days or less) can be temporarily suspended in the program and resume when the client is able to participate in services.

220.950 Documentation of Intensive Care Coordination in Client File 1-1-23

Providers must develop and maintain sufficient written documentation for each client being served. This documentation, at a minimum, must consist of:

A. Signed consent by client, or client's legal guardian, to receive services and share data with DHS, community partners

B. Date services begin and referral documentation

C. A copy of all PCAPs, home-visiting assessments, and HRSN assessments

D. Services or supports rendered or obtained by client

E. Referrals and outcomes of referrals for HRSN

F. The date and time intensive care coordination occurs

G. The name and title of the individual who provided the service

H. Updates for each client contact describing the client's progress toward milestones and goals and any concerns/issues with engagement

I. Completed forms as required by DHS or other entity

Additional documentation and information may be required depending on the service to be provided.

230.000 PAYMENT DETAILS

230.100 Allowable Life360 costs 1-1-23

Subject to the funding limits in the ARHOME 1115 Waiver, DHS will review, approve, and make payments for Life360 funding in accordance with the requirements in the 1115 demonstration Special Terms and Conditions and other CMS requirements. DHS will make payments directly to the approved and enrolled hospitals. Life360 funding must not supplant funding provided by other federal, state, or local funding sources.

Providers must attest during readiness review to DHS that they have appropriate fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer. Expenditure authority will make funding available to selected Medicaid-enrolled hospitals for:

A. Intensive care coordination service for target populations, including direct costs of recruiting, training, and employing care coordinators to provide intensive care coordination to the targeted Life360 population

B. Indirect costs necessary to support ongoing project costs such as information technology or personnel directly responsible for the project including fiscal, programmatic, etc.

C. Startup costs necessary for the development of capacity, infrastructure, and systems to begin the program, complete a community network assessment, and formulate partners/subcontractors, and

D. Nonmedical client supports as outlined in this manual.

Medical care costs are not reimbursable and should be billed as usual through the client's Medicaid program.

More details on included costs for each type of Life360 are described in 210.700, Program Funding.

Capital improvement costs beyond specific allowed costs are not allowable. Please refer to HRSN-reimbursable costs in this manual in 240.000, Glossary and in 210.700, Program Funding sections for more details on allowable expenditures.

230.200 Maternal Life360 Payment and Reporting 1-1-23

A. Arkansas Medicaid will pay the Maternal Life360 a per member per month (PMPM) fee based on the established program rates.

1. Providers must enroll clients to receive the PMPM payment for each enrollee.
2. Refer to the Rate Sheet for the current fee. Fees will be updated based on rate review on an as needed basis.

B. Startup payment and monthly transportation fees will be paid to the hospital's provider ID.

C. Programs will be able to reconcile cost differences at the end of the year (or more frequently) based on any changes to their program that may warrant a rate adjustment within the established program rate structure.

230.300 Rural Life360 Payment and Reporting~~Instructions~~ 1-1-23

Startup payments and monthly ~~P~~payment will be made to the hospital's provider ID per the terms of the Life360 HOME agreement.

Reporting requirements by cost type:

A. Intensive Care Coordination: The Life360 will complete monthly cost reports using the DHS approved form. The report should be for the actual cost of care coordination services and community HRSN screenings and indirect costs for that month. The amount may vary based on ongoing expenditures/costs but will not exceed the total approved annual budget in the Life360 HOME agreement.

B. Transportation/Emergency Equipment and Training: The Life360 will ~~P~~prepare and submit a monthly cost report for the prorated annual transportation and emergency equipment and training expenditures.

C. Startup: The Life360 shall provide start-up cost(s) once DHS approves successful completion of the application or readiness review and the Life360 has submitted a signed agreement. Startup costs will be reported monthly.

230.400 Success Life360 Payment and Reporting 1-1-23

Monthly payment will be made to the hospital's provider ID per the terms of the Life360 HOME agreement.

Reporting requirements by cost type:

A. Intensive Care Coordination: The Life360 will complete monthly cost reports using the DHS approved form. The report should be for the actual cost of care coordination services and indirect costs for the month. The amount may vary based on ongoing expenditures/costs but will not exceed the total approved annual budget in the Life360 HOME agreement.

B. Technology: The Life360 will ~~P~~prepare and submit a monthly report for the prorated annual technology costs.

C. Success payments: At the end of each year, Life360 will submit a request for payment for the number of clients who have been approved for Success payments by DHS. See Program Funding section for more details.

D. Startup: The Life360 shall receive payment for the approved startup cost(s) once DHS approves successful completion of the application or readiness review and the Life360 has submitted a signed agreement. Startup costs will be reported monthly.

240.000 GLOSSARY

Acute care hospital means a hospital that:

A. Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

B. Is enrolled as a provider with the Arkansas Medicaid Program.

Birthing hospital means a hospital in this state or in a border state that:

A. Is licensed as a general hospital;

B. Provides obstetrics services; and

C. Is enrolled as a provider with the Arkansas Medicaid program.

Care coordination coaches mean those individuals who establish relationships with their clients to ensure effective participation in the Rural Life360 program. Coaches may work under various titles including peer specialists, peer counselors, family support workers, and home visitors. They work directly with clients and their families to improve their life skills to be physically, socially, and emotionally healthy to live successfully in their communities.

Community services mean any resource or services provided by public or private organizations to community residents to assist with a particular social need such as mental health or counseling or health-related needs including housing or food or job training and employment. It may also include other general services or programs offered through libraries or other local government funding that benefit the community.

Evidence-based home visitation means a home visitation program that is ~~based on~~ one of the models recognized by the U.S. Department of Health and Human Services to be effective in improving maternal and child health.

High-risk pregnancy means a pregnancy with a diagnostic code of supervision of high-risk pregnancy, as evidenced by a physician or Advanced Practice Registered Nurse (APRN) referral. High-risk diagnosis includes medical and/or social risk.

Home-visiting means an evidence-based program that provides direct support and intensive care coordination of services for clients served by Maternal Life360s with the goals of improving maternal and infant health outcomes, promoting child development and school readiness, connecting families to needed community resources and supports, and increasing a family's education and earning potential.

HRSN reimbursable cost means time-limited expenses to enable a client to access services or supports to meet an identified HRSN allowable under Life360. These must be identified through a Health-Related Social Needs (HRSN) screening, or the client's engagement with the care coordinator, and are transitional in nature. Examples include housing safety inspections, pest control, security deposit and first month's rent that is required to obtain a lease on an apartment or home, and nutritional instruction for disease control/prevention.

HRSN screening means a standardized way of capturing a Life360 client's health-related social needs to determine any needs or barriers a client may experience at the time of screening. For example, an individual may have trouble paying rent on time and be at risk of losing their apartment. A pregnant individual may experience difficulty going to her doctor's appointments due to not having a car and lack resources for food. Information gathered through the screening may be used to help inform care coordination plans or referrals to community services and supports.

Individual Qualified Health Plan (QHP) means an individual health insurance benefit plan offered in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations.

Intensive care coordination is an umbrella term for a collaborative process in which a care coordinator or others assess, plan, implement, coordinate, monitor and evaluate the options, services and supports required to meet the client's health and HRSN needs. It is characterized by advocacy, communication, and resource management, and promotes quality interventions and outcomes. In addition to addressing medical services, care coordination coaches ensure that clients have safe housing, employment, education, financial stability, and emotional/mental wellness.

Mental illness refers to clients with a diagnosis of one or more of the following: neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar

and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, and personality disorders.

Non-Reimbursable Community Contribution (NRCC) means a payment, including an in-kind payment, for goods or services provided to a client to assist the client with meeting a HRSN identified in the client's person-centered action plan but is not a HRSN-reimbursable cost or reimbursable through other Medicaid funds under the Life360 HOME agreement. NRCC may include rent or utility costs for example, or excluded categories (i.e. job preparation expenses such as clothing or personal care). The identification of sources of NRCC and the types of NRCC provided shall be included in the application and in program reports.

Partner agreement means the sub contractual agreement executed between the Life360 and its partner subrecipients. The subrecipient has its performance measured against whether the objectives of the program as outlined in the Life360 HOME agreement between DHS and the Life360 are met; has responsibility for programmatic decision-making; and uses funds to carry out the program by providing goods or supports to clients. Subrecipients are identified in the application and in programmatic and financial reports. Additional subrecipients can be requested during the program period by contacting the Life360 program manager at DHS. Subrecipients will need to be updated into the Life360 HOME agreement.

Person-Centered Action Plan (PCAP) means a plan completed by the Life360 that identifies a client's strengths, preferences and includes information from the HRSN screen and additional information gathered from the client through meetings and any other tools utilized by the program. The PCAP includes short and longer-term goals and objectives to address the client's HRSN and other personal goals as well as details on how and what services and supports will be obtained, a crisis plan, and documentation of progress on goals and successes and barriers encountered. The PCAP is updated as the client meets goals, circumstances change, or the sets new goals.

Life360 HOME agreement means the administrative instrument to be executed between the Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) and an Arkansas Medicaid enrolled hospital Life360 provider.

Rural area means an Arkansas county where a hospital designated as a critical access hospital or participant in the Small Rural Hospital Improvement Program is located or an Arkansas county with a population of fifty-thousand (50,000) or less.

Small rural hospital means a critical access hospital or a general hospital that:

A. Is located in a rural area;

B. Has fifty (50) or fewer staffed beds; and

C. Is enrolled as a provider in the Arkansas Medicaid program.

Health-Related Social Needs (HRSN) means conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Veteran means a person who served in the active military, naval, or air service and who was discharged or released there-from, as verified by DD214 documentation.

Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

PROPOSED

June, 2012

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Arkansas requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Maternal Life360 HOME.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
☑ an initial request for new waiver. All sections are filled.
☐ a request to amend an existing waiver, which modifies Section/Part ____
☐ a renewal request

Section A is:
☐ replaced in full
☐ carried over with no changes
☐ changes noted in **BOLD**.

Section B is:
☐ replaced in full
☐ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of dd 2 years beginning 01/01/23 and ending 12/31/24.

State Contact: The State contact person for this waiver is Elizabeth Pitman and can be reached by telephone at (501) 244-3944, or fax at (___) _____, or e-mail at elizabeth.pitman@dhs.arkan. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

There are no federally recognized tribes in Arkansas.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment A

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment B

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   ☑ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a. ☐ **Section 1902(a) (1) - Statewideness**
   b. ☑ **Section 1902(a) (10) (B) - Comparability of Services**
   c. ☑ **Section 1902(a) (23) - Freedom of Choice**
   d. ☐ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ☑ the same as stipulated in the State Plan
   ☐ is different than stipulated in the State Plan (please describe)

2. **Procurement**. The State will select the contractor in the following manner:

   ☐ **Competitive** procurement
   ☐ **Open** cooperative procurement
   ☐ **Sole source** procurement
   ☑ **Other** (please describe) See Attachment C

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   ☐ Beneficiaries will be limited to a single provider in their service area.

   ☑ Beneficiaries will be given a choice of providers in their service area.

   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

N/A

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

- [x] Section 1931 Children and Related Populations
- [x] Section 1931 Adults and Related Populations
- [x] Blind/Disabled Adults and Related Populations
- [x] Blind/Disabled Children and Related Populations
- [ ] Aged and Related Populations
- [x] Foster Care Children
- [x] Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

- [ ] Dual Eligibles
- [ ] Poverty Level Pregnant Women
- [ ] Individuals with other insurance
- [ ] Individuals residing in a nursing facility or ICF/MR
- [ ] Individuals enrolled in a managed care program
- [ ] Individuals participating in a HCBS Waiver program
- [ ] American Indians/Alaskan Natives

☐ Special Needs Children (State Defined). Please provide this definition.
☑ Individuals receiving retroactive eligibility
☑ Other (Please define):

Women eligible for Medicaid through the New Adult Group (ARHOME) will receive services through the Section 1115 Demonstration

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

See Attachment D

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2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment D

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment E

PROPOSED

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment E

B. Utilization Standards

Describe the State's utilization standard specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

See Attachment F

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment F

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

See Attachment G

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

See Attachment G

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment H

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

See Attachment I

B. Individuals with Special Needs.

☑ The State has special processes in place for persons with special needs (Please provide detail).

See Attachment J

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

The per member per month (PMPM) cost estimates are based on DHS' expectations of the program incurring first-year service costs of $300 PMPM, along with associated administrative costs of $15.43 PMPM (consistent with program-wide administrative costs). Since this will be a new service offered under the waiver, the projected cost was independently developed rather than relying on historical service experience. As such, the projected pre-waiver cost is identical to the projected waiver cost, as there is not any

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 01/01/23 to 12/31/23

Trend rate from current expenditures (or historical figures): 5.00 0.00% %

Projected pre-waiver cost $315.43
Projected Waiver cost
Difference

Year 2 from: 01/01/24 to 12/31/24

Trend rate from current expenditures (or historical figures): 5 0.00% %

Projected pre-waiver cost $331.20
Projected Waiver cost $331.20
Difference: $0.00

Year 3 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 4 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost
Difference: _____

Year 5 (if applicable) from: __/__/____ to __/__/____
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

PROPOSED

Attachment A: Program Description

In January 2022, Arkansas Medicaid replaced the Arkansas Works program by implementing the Arkansas Health and Opportunity for Me program (ARHOME), which was passed by the Arkansas General Assembly as Act 530 of the 2021 Regular Session. ARHOME provides coverage for eligible individuals ages 19-64 who are in the Adult Expansion Group. As part of the new ARHOME program, Arkansas is creating a Maternal Life360 HOME program –that will create Community Bridge Organizations (CBOs), known as Life360 HOMEs, for women enrolled in ARHOME who have been diagnosed with a high-risk pregnancy. Maternal Life360 HOME (Maternal Life360) was developed to address the state's low-ranking in maternal and child health indicators and high rates of maternal morbidity and mortality. The goal of the Maternal Life360 HOME is to improve state maternal health and child health outcomes, particularly birth outcomes, and other maternal health indicators, including prenatal visits and postpartum contraceptive use.

Medicaid finances more than 60 percent of all births in Arkansas. To improve the state's ranking and the lives of moms and babies, Arkansas must focus on all high-risk pregnancies in the Arkansas Medicaid population, not just those in the ARHOME population. In Arkansas, Medicaid spends approximately $140 million each year on costs related to poor birth outcomes.

This waiver will expand the Maternal Life360 HOME program to pregnant women in any Medicaid aid category with a high-risk pregnancy. High risk pregnancy is defined as a pregnancy with a diagnostic code that requires supervision of high-risk pregnancy, as evidenced by a physician or Advanced Practice Registered Nurse (APRN) referral. For eligible women, services can begin at any point during pregnancy and will continue up to one (1) year after the birth of the baby.

Expanding the Maternal Life360 HOME services to women with high-risk pregnancies in all Medicaid aid categories will promote greater use of preventative care services, reduce non-emergent use of emergency department services, lower the use of potentially preventable emergency department services, reduce the likelihood of preventable hospital admissions and readmissions, and result in improved birth outcomes for infants.

Only evidence-based home-visitation models—those defined as meeting the U.S Department of Health and Human Services department's criteria as an evidence-based home visiting service delivery model—will be used to support the mother and the child.

There are currently four evidence-based home-visiting programs in use in Arkansas that serve families at some point between pregnancy and the baby's first two years of life:

- Healthy Families America
- Nurse Family Partnership
- Early Head Start
- Parents as Teachers

Attachment B: Waiver Services

Maternal Life360 HOME

Women with high-risk pregnancies who are eligible for Medicaid but are not in the New Adult Medicaid Expansion Group can receive home-visiting services.

DHS will contract with approved Life360 hospitals to provide evidence-based home visiting services to women with a diagnosis code of high-risk pregnancy who live in the Life360's selected service area. The services start during pregnancy and will be provided through the baby's first 12 months. Client participation is voluntary, and the home visiting services are supplemental to the medical services they are already receiving through Medicaid.

Home visiting activities include

- Assessing the client and her family's health-related social needs
- Providing clients with education and support on prenatal health, birth preparation and newborn care
- Helping navigate medical care and addressing barriers that could prevent regular prenatal visits and well child visits
- Assisting with accessing needed resources and services, including referring to community and state resources, such as food banks, WIC, and housing services.
- Assisting with enrollment in education or workforce training programs and gaining employment.

Attachment C: Delivery Systems, Procurement

Any entity that meets the licensure and provider requirements may participate. First, the entity must be a “birthing hospital” as defined by Arkansas Act 530 of 2021 and be enrolled as an Arkansas Medicaid provider. The hospital must either directly offer or contract with a home visiting provider to offer evidence-based home visiting services. Each entity must then apply to participate and be approved by DHS. Approved Life360s then will sign a Maternal Life360 Provider Agreement with DHS to enroll become a Maternal Life360 HOME.

C. Restriction of Freedom of Choice

1. Provider Limitations Areas of the state where the waiver program will be implemented: The program will be implemented in any area of the state where DHS approves a qualified Life360 HOME provider to operate.

Clients will enroll in a Life360 HOME based on the defined catchment are and the provider's capacity to serve them.

Attachment D: Timely Access Standards

1. To participate in the Maternal Life360 HOME waiver program, the provider must maintain fidelity to an evidence-based home-visiting model, including appropriately timed home visits in accordance with the guidelines set in this waiver. The guidelines provide flexibility for the visiting care coordinator to also consider the individual needs of the family when scheduling home visits. Hospitals enrolled as Maternal Life360 HOMEs will be required to develop and implement written policies and procedures to ensure clients receive timely access to appropriate home visit services tailored to the specific needs of each client. DHS will also monitor time from client enrollment to first home visit.
2. The notices clients receive when they are enrolled in the Life360 HOME will provide a phone number they can call if they are unable to schedule a home visit within the first 30 days of enrollment. DHS will monitor the time from client enrollment to first home visit as well as client complaints captured by the call center to ensure the Life360 HOME is providing timely service. If the Life360 HOME is not providing timely services, DHS may impose corrective actions that could include a corrective action plan, caps on funding, recoupment of funds or discontinuation of Life360 funding.

Attachment E: Provider Capacity Standards

The home visiting services provided through the Maternal Life360 HOME program will be supplemental to Medicaid State Plan services and will be offered in regions of the state where DHS-approved hospitals choose to establish the services. Because this is a voluntary service for a provider to provide, some areas of the state may not provide access to Life360 HOME services. However, over time, DHS believes the program will be considered a critical part of providing care to high-risk pregnant women and economically feasible enough to entice a significant number of hospitals to participate.

1. In the first year of the program, DHS anticipates five hospitals will become Maternal Life360 HOMEs, serving 2,000 clients (some of whom will be enrolled in ARHOME and served through the Section 1115 ARHOME waiver). In the second year, DHS estimates five more facilities will become approved Life360 HOMEs for a total of 10 facilities serving 3,000 clients. Ten hospitals participating would mean more than a quarter of the state's hospitals with an obstetrics unit would be providing home visiting services.
2. When new hospitals apply to become a Life360 HOME, DHS will consider the extent to which the hospital's proposed service area is adequately served and will work with hospitals to develop partnerships that allow for greater coverage across the state. DHS will encourage hospitals applying to become a Life360 HOME to include in their service area counties without birthing hospitals, so that home visiting services can support prenatal care where there is a scarcity of obstetric specialists.

Attachment F: Utilization Standards

1. To participate in the Maternal Life360 HOME waiver program, the provider must maintain fidelity to an evidence-based home-visiting model, including appropriately timed home visits in accordance with the guidelines of that evidence-based model set out in this waiver. The guidelines provide flexibility for the visiting care coordinator to also consider the individual needs of the family when scheduling home visits. Hospitals enrolled as Maternal Life360 HOMEs will be required to develop and implement written policies and procedures to ensure clients receive timely access to appropriate home visit services tailored to the specific needs of each client. Whiles these policies and procedures are agency (Life 360 HOME) specific, the agency is responsible for ensuring the policies and procedures are consistent with the evidence-based home visiting model.

   At a minimum, DHS expects clients to receive a home visit at least every 30 days. DHS requires Life360 HOMEs to disenroll and notify any client that 1.) has not received a visit in 30 days and 2.) at least three contact attempts have been made to reach the client. Life360s will be required to document visits made by entering encounters (or some other method) in the MMIS system. DHS will monitor MMIS-generated reports of encounters monthly to ensure all clients are seen at least every 30 days. Clients who have been disenrolled can re-enroll if they remain eligible by renewing their consent to participate with their signature.

2. Life360s must meet acceptable performance, including serving the targeted number of clients and providing the number of visits specified in the Life360 HOME agreement. DHS will ensure that Life360s meet acceptable performance and that action is taken to address any identified non-compliance with Life360 funding parameters. If DHS determines that a Life360 has failed to demonstrate appropriate performance, including insufficient client utilization, DHS may impose corrective actions that could include:

   A. A corrective action plan

   B. Limits on funding

   C. Recoupment of funds

   D. Discontinuation of Life360 funding

Attachment G: Quality Standards and Contract Monitoring

1. DHS will establish quality standards that measure services obtained as well as health outcomes. The State will monitor performance on these standards through two reporting mechanisms: quarterly reporting and annual quality metric calculations. Maternal Life360 HOMEs will be expected to report specified data quarterly, including the number of pregnant women who received prenatal care, deliveries, pre-term deliveries, type of delivery (e.g., C-section), birth weight, babies who receive well-child visits and immunizations, infant/maternal deaths and visits to the emergency room.

   Annually, DHS will use claims data, birth certificate data and other available data resources to calculate quality metrics that follow the Adult/Child Core Set, HEDIS or other established metric specification. The metrics will be calculated for all the Maternal Life360 HOMEs and for each one individually, where the participation numbers are high enough to calculate a metric.

   Life360 HOMEs will be expected to meet goals for process metrics and health outcomes established in their provider agreement. The process metrics and health outcomes will be used for program improvement and for corrective action plans, if necessary. Each year in the third quarter of the year, DHS will provide to the Life360 HOMEs their performance calculations on metrics (e.g., percent of low birthweight babies delivered, percent of deliveries that were pre-term) for the prior calendar year. DMS will review the quarterly data reported by the Life360 HOME and its performance on the annual metrics. The Life 360 HOME will address performance successes and weaknesses as part of its annual agreement for the next year.

   DHS will also monitor fidelity to the evidence-based model by ensuring the program remains accredited/affiliated with the parent organization of the model.

   The State also will track and monitor quality outcomes for purposes of conducting a rigorous independent evaluation of the Maternal Life360 Home program. As part of the performance review of the project, the state will collect and analyze quality data, including birth outcomes, rates of deliveries by elective C-section, use of preventative and other primary care services, use of emergency department services for non-emergent care, use of potentially preventable emergency department services and preventable hospital admissions, Medicaid expenditures among mothers and children up to one year after birth and improvements in health-related social needs.

2. DHS will establish standards that measure services the Life360 HOME provides. The State will monitor performance on these standards through monthly expenditures reporting and quarterly progress reporting. Life360 HOMEs will use the MMIS system to enroll clients and enter visits provided so that DMS can monitor client enrollment and services rendered.

   DHS will ensure that Life360s meet acceptable performance and that action is taken to address any identified non-compliance with Life360 funding parameters. If DHS determines that a Life360 has failed to demonstrate appropriate performance, including enrolling an insufficient number of clients, DHS may impose corrective actions that could include:

   A. A corrective action plan

B. Limits on funding

C. Recoupment of funds

D. Discontinuation of Life360 funding

DHS also may impose corrective actions for a Life360 if it determines the Life360 is out of compliance with requirements included in the Life360 HOME agreement and/or policy letters or guidance set forth by DHS or CMS ARHOME 1115 Demonstration Special Terms & Conditions or the CMS 1915(b) Standard Terms & Conditions.

Attachment H: Coordination and Continuity of Care Standards

The home visiting services provided through the Maternal Life360 HOME program will be supplemental to Medicaid State Plan services and will be offered in regions of the state where DHS-approved birthing hospitals choose to establish the services. The State believes these services will enhance the coordination and continuity of care in the areas where they are established. Home visitors will help their clients navigate the medical system and ensure they are accessing and receiving needed medical care. Additionally, the State anticipates the Maternal Life360 HOME program will provide vital care coordination services in areas without a birthing hospital when birthing hospitals that become Maternal Life360 HOMEs extend their service areas beyond their county borders.

Attachment I: Client Information

Clients may receive information about the Life360 HOME through their OB/GYNs or through the Life360 HOME's community network. The State expects the Life360 HOME to have robust outreach to community partners (e.g., food banks, homeless shelters, local WIC programs) to be able to refer clients to services, but also to ensure the community partner refer clients to the Life360 HOME.

Additionally Medicaid or ARHOME qualified health plans may send mailers, postcards or emails to clients identified as potential Life360 clients based on high-risk pregnancy diagnosis code reported through claims data.

Each Life360 HOME may have a website for information regarding its home visiting services, referral network, and community resources. This website may be linked to the DHS Life360 HOME webpage that provides information for clients about Life360 enrollment. The Life360 HOME may also produce written marketing materials to distribute to enrollees and potential enrollees.

The Maternal Life 360 Home Providers will be required to provide all allowable written marketing materials in English, Spanish, and Marshallese if, in any county in the Life360's service area, the county population is comprised of at least 3% or more of individuals who speak the language.

Attachment J: Individuals with Special Needs

Each Life360 HOME must provide auxiliary aids and services to clients with special needs upon request, including, but not limited to, interpreter services and toll-free numbers with TTY/TTD capability.

The development of a person-center action plan (PCAP) is a requirement of the Maternal Life360 HOME program. This PCAP must include the services and supports necessary to meet each identified special need of the client.

State of Arkansas *As Engrossed: S3/8/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 410

By: Senator Irvin
By: Representative M. Gray

For An Act To Be Entitled

AN ACT TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; TO PROMOTE ECONOMIC AND PERSONAL HEALTH, PERSONAL INDEPENDENCE, AND OPPORTUNITY FOR ARKANSANS THROUGH PROGRAM PLANNING AND INITIATIVES; TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; AND TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 61, Subchapter 10 is amended to read as follows:

Subchapter 10 — ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021

23-61-1001. Title.

This subchapter shall be known and may be cited as the "~~Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021".

23-61-1002. Legislative intent.

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

~~(1) Empowers individuals to improve their economic security and achieve self-reliance;~~

~~(2) Builds on private insurance market competition and value-based insurance purchasing models;~~

~~(3) Strengthens the ability of employers to recruit and retain productive employees; and~~

~~(4)~~(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for ~~entitlement spending~~ providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

23-61-1003. Definitions.

As used in this subchapter:

~~(1) "Cost-effective" means that the cost of covering employees who are:~~

~~(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or~~

~~(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;~~

(1) "Acute care hospital" means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) "Birthing hospital" means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) "Community bridge organization" means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting

their long-term goals to achieve independence, including economic independence;

~~(2)~~(4) "Cost sharing" means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) "Critical access hospital" means an acute care hospital that is:

(A) Designated by the Centers for Medicare and Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) "Economic independence initiative" means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

~~(3)~~(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

~~(4)~~(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

~~(5)~~(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on ~~January 1, 2016~~ January 1, 2021;

~~(6)~~(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in

Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

~~(7)~~(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; ~~or~~

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

~~(8)~~(14) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer ~~through~~ that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on ~~January 1, 2016~~ January 1, 2021;

(15) "Member" means a program participant who is enrolled in an individual qualified health insurance plan;

~~(9)~~(16) "Premium" means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health

insurance benefits;

~~(10)~~(17) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined ~~to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:~~ by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

~~(i) An individual who is medically frail; or~~

~~(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and~~

~~(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.~~

~~(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016~~

(18) "Risk-based provider organization" means the same as defined in § 20-77-2703; and

(19) "Small rural hospital" means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

23-61-1004. Administration ~~of Arkansas Works Program~~.

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other ~~necessary~~ state agencies, as necessary, shall:

(A) Provide ~~health insurance or medical assistance~~ healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program by:~~;~~

~~(C)~~(i) ~~Submit and apply~~ Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare and Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

~~(D)~~(E) Offer ~~incentive benefits~~ incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

~~(E)~~(F) Seek a waiver to ~~eliminate~~ reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

(b) ~~Health insurance benefits~~ Healthcare coverage under this subchapter shall be provided through enrollment in:

(1) ~~Individual premium assistance for enrollment of Arkansas Works Program participants in~~ An individual qualified health insurance ~~plans~~ plan through a health insurer; ~~and~~

(2) ~~Supplemental benefits to incentivize personal responsibility~~ A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) Fee-for-service Medicaid program.

(c) ~~The~~ Annually, the Department of Human Services~~, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.~~ shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of *understanding.*

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and

(3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

~~(d)(1)~~(f)(1) ~~If the~~ ~~Within thirty (30) days of a reduction in~~ federal medical assistance percentages ~~as described in this section~~ for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare and Medicaid Services a plan within thirty (30) days of the reduction to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of ~~a~~ the reduction ~~in any of the following federal medical assistance percentages:~~

~~(A) Ninety-five percent (95%) in the year 2017;~~

~~(B) Ninety-four percent (94%) in the year 2018;~~

~~(C) Ninety-three percent (93%) in the year 2019; and~~

~~(D) Ninety percent (90%) in the year 2020 or any year after the year 2020~~.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

~~(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.~~

~~(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.~~

~~(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:~~

~~(A) Eligibility and enrollment;~~

~~(B) Utilization;~~

~~(C) Premium and cost-sharing reduction costs;~~

~~(D) Health insurer participation and competition;~~

~~(E) Avoided uncompensated care; and~~

~~(F) Participation in job training and job search programs.~~

~~(2)(A)~~(g)(1) A health insurer ~~who~~ that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the ~~State Insurance Department~~ Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

~~(B)~~(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

23-61-1005. Requirements for eligible individuals.

~~(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:~~

~~(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and~~

~~(B) The first year of, and thereafter annually:~~

~~(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or~~

~~(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.~~

~~(2) Failure to meet the requirement in subdivision (a)(1) of~~

~~this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:~~

~~(A) Incentivize and increase work and work training opportunities; and~~

~~(B) Participate in job training and job search programs.~~

~~(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.~~

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual's individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through fee-for-service Medicaid.

(B) An eligible individual who is enrolled in the fee-for-service Medicaid program is exempt from the requirements of subsection (a) of this section.

~~(c)~~(d) An eligible individual shall receive notice that:

(1) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity

for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice; ~~and~~

(3) ~~The Arkansas Works Program is not an entitlement program~~ Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

23-61-1006. Requirements for program participants.

~~(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).~~

~~(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.~~

~~(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:~~

~~(A) The accrual of a debt to the State of Arkansas; and~~

~~(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.~~

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or

more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

23-61-1007. Insurance standards for individual qualified health insurance plans.

(a) Insurance coverage for a ~~program participant~~ member enrolled in an

individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on ~~January 1, 2016~~ January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) ~~The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a program participant enrolled in an individual qualified health insurance plan~~ As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) ~~All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace~~ All health benefit plans purchased by the Department of Human Services shall:

(1)~~(A) Offer individual qualified health insurance plans conforming~~ Conform to the requirements of this section and applicable insurance rules~~.~~;

~~(B)~~(2) Be certified by the State Insurance Department; ~~The individual qualified health insurance plans shall be approved by the State Insurance Department; and~~

~~(2)~~(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on ~~January 1, 2016~~ January 1, 2021, or rebate the difference to the Department of Human Services for ~~program participants~~ members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established

by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Service and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

~~(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.~~

~~(e)~~(d) A health insurer offering individual qualified health insurance plans for ~~program participants~~ members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including ~~program participants~~ members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement programs as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before ~~January 1, 2017~~ January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

~~23-61-1008. [Expired.]~~

23-61-1009. Sunset.

This subchapter shall expire on ~~December 31, 2021~~ December 31, 2026.

23-61-1010. Community bridge organizations.

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the

Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs *local qualified staff* to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through

telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel.

(a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.

(b) The advisory panel shall be composed of the following members:

(1) The following members of the General Assembly:

(A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;

(B) The Chair of the House Committee on Public Health, Welfare, and Labor;

(C) The Chair of the Senate Committee on Education;

(D) The Chair of the House Committee on Education;

(E) The Chair of the Senate Committee on Insurance and Commerce;

(F) The Chair of the House Committee on Insurance and Commerce;

(G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;

(H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;

(I) An at-large member of the Senate appointed by the minority leader of the Senate; and

(J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;

(2) The Secretary of the Department of Human Services;

(3) The Arkansas Surgeon General;

(4) The Insurance Commissioner;

(5) The heads of the following executive branch agencies or their designees;

(A) Department of Health;

(B) Department of Education;

(C) Department of Corrections;

(D) Department of Commerce; and

(E) Department of Finance and Administration;

(6) The Director of the Arkansas Minority Health Commission; and

(7)(A) Three (3) community members who represent health, *business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the* health and welfare of Arkansans, appointed as follows;

(i) One (1) member shall be appointed by and serve at the will of the Governor;

(ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and

(iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.

(B) Members serving under subdivision (b)(6)(A) of this section may receive mileage reimbursement.

(c)(1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the co-chairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.

(2) The legislative member who serves as the co-chair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality

performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating Individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the

Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

20-61-1012. Rules.

The Department of Human Services shall adopt rules necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-984(b)(2)(D), concerning the Division of Workforce Services Special Fund, is amended to read as follows:

(D) The ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor; and

SECTION 3. Arkansas Code § 19-5-1146 is amended to read as follows:

19-5-1146. ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "~~Arkansas Works Program~~ Arkansas Health and Opportunity for

Me Program Trust Fund".

(b) The fund shall consist of:

(1) Moneys saved and accrued under the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation:

(A) Increases in premium tax collections; and

(B) Other spending reductions resulting from the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; and

(2) Other revenues and funds authorized by law.

(c) The Department of Human Services shall use the fund to pay for future obligations under the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program created by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

SECTION 4. Arkansas Code § 23-61-803(h), concerning the creation of the Arkansas Health Insurance Marketplace, is amended to read as follows:

(h) The State Insurance Department and any eligible entity under subdivision ~~(e)(1)~~ (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program established by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

SECTION 5. Arkansas Code § 23-79-1601(2)(A), concerning the definition of "health benefit plan" regarding coverage provided through telemedicine, is amended to read as follows:

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 6. Arkansas Code § 23-79-1801(1)(A), concerning the definition of "health benefit plan" regarding coverage for newborn screening for spinal muscular atrophy, is amended to read as follows:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 7. Arkansas Code § 26-57-604(a)(1)(B)(ii), concerning the remittance of the insurance premium tax, is amended to read as follows:

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

SECTION 8. Arkansas Code § 26-57-610(b)(2), concerning the disposition of the insurance premium tax, is amended to read as follows:

(2) The taxes based on premiums collected under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B) Transferred to the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund and used as required by the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund;

SECTION 9. EFFECTIVE DATE.

This act is effective on and after January 1, 2022.

/s/Irvin

APPROVED: 4/1/21