



ARKANSAS COMPREHENSIVE UNWINDING PLAN

February 2023



**ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES**



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Arkansas's Comprehensive Plan to Unwind Medicaid Continuous Enrollment

Overview

The COVID-19 pandemic and declaration of a national public health emergency (PHE) and associated measures allowed for continuous Medicaid coverage for millions of Americans during the pandemic, but also upended normal eligibility and enrollment processes across the country beginning Spring of 2020 and allowed ineligible beneficiaries to remain covered. In December 2022, the federal Consolidated Appropriations Act, 2023, gave states the authority to begin the process of re-determining eligibility for Medicaid enrollees kept on the Medicaid rolls due to the continuous coverage requirement beginning April 1, 2023, and to reinstate routine eligibility operations. Arkansas is moving swiftly to unwind the continuous enrollment condition to protect taxpayers and to restore the integrity of the Arkansas Medicaid program. CMS has issued guidance states must follow through the unwinding:

- January 27, 2023 ([link](#))
- January 5, 2023 ([link](#))
- March 3, 2022 ([link](#))
- August 13, 2021 ([link](#))
- December 22, 2020 ([link](#))

Unwinding the continuous enrollment condition will be one of the largest and most complex efforts for state Medicaid programs since the implementation of the Affordable Care Act almost a decade ago. States, including Arkansas, will face challenges during the unwinding, particularly related to workload and staffing. Arkansas is positioned to address workload and staffing challenges because the State:

- Continued to process renewals and conduct re-determinations throughout the continuous enrollment condition, while some states put that work on hold
- Has increased its eligibility workforce through contractor support and filling of vacant positions to help address a backlog of casework in advance of the unwinding period. Seasoned contracted staff will remain in place through the unwinding and because of the work they are doing now, will be comfortable with the State's processes and systems when the unwinding begins.
- Has all Medicaid and Supplemental Nutrition Assistance Program (SNAP) cases in one eligibility system for the first time in a decade.
- Has an umbrella human service agency that allows Medicaid to communicate across divisions to reach populations by working with program – not just eligibility – staff to support, engage, and assist beneficiaries at risk of losing coverage.

The State also is building in safeguards, new processes, and outreach efforts to protect both the taxpayers and eligible beneficiaries; testing and monitoring our information technology systems; and doing extensive planning to help mitigate risks and put Arkansas in the best position to transition to



routine eligibility and enrollment operations. All of this is outlined in detail in this document, Arkansas's Comprehensive Plan to End Medicaid Continuous Enrollment.

The goals of the unwinding plan are simple yet critically important:

- Protect taxpayers by removing ineligible clients from the rolls
- Ensure that Arkansas only pays for medical assistance for eligible individuals and avoids making payments on behalf of ineligible individuals
- Ensure workloads are manageable for staff throughout the unwinding
- Process renewals and make re-determinations accurately and timely to ensure continuity of coverage for eligible individuals and keep casework current throughout the unwinding
- Ensure minimum disruptions for Medicaid providers for claims submission and certification
- Make the process easy and beneficiary-friendly
- Support coverage transitions for individuals who are no longer eligible to ensure continuity of coverage
- Re-establish a renewal schedule that is sustainable moving forward

So what does “unwinding” actually mean in terms of eligibility and enrollment? After the start of the COVID-19 pandemic, federal legislation authorized significant changes to Medicaid programs. In the March 2020 [Families First Coronavirus Response Act](#), states were provided an increase of 6.2 percentage points in federal Medicaid matching funds if states agreed to provide continuous eligibility through the end of the month during which the PHE ends for anyone enrolled as of March 18, 2020, or after. That meant no Arkansans could be removed from the Medicaid rolls for a change in income or eligibility until the PHE ends. Cases have been closed only if individuals moved out of state, died, are incarcerated, or requested their coverage end. Because the Arkansas Department of Human Services (DHS) Division of County Operations (DCO) continued to conduct renewals and re-determinations, the State has identified **586,998** individuals as no longer eligible based on information available to DHS at the time of their renewal. Reasons beneficiaries could be no longer eligible include that they:

- Have an income that now exceeds eligibility levels
- Have not responded to a request for information as part of the renewal process
- Had a level of care or medical change that made them no longer eligible
- Have aged out of eligibility

These cases have been “extended” due to the continuous enrollment condition. Beneficiaries were allowed to submit proof of eligibility throughout the PHE and as a result, **133,881** individuals no longer eligible transitioned from extended to a coverage category for which they were eligible, ensuring continuity of coverage for these individuals. In addition, **31,005** individuals no longer eligible had their cases closed for allowable reasons. This leaves **422,112** individuals with extended cases who will need to have their eligibility re-determined because their circumstances may have changed, and they may remain eligible. Overall, Arkansas Medicaid is at its highest enrollment ever with **1.138** million beneficiaries, up **23.6** percent from March 2020. This unprecedented level of enrollment is due in large part to the continuous enrollment condition and mirrors the experiences of other state Medicaid programs.



One concern nationwide is that eligible beneficiaries, especially more vulnerable populations like those who are aged, disabled, or who have developmental/intellectual disabilities, will lose coverage during the unwinding because states were not given updated contact information and cannot reach them. That is a real concern in Arkansas, and the State is taking steps to mitigate this, including:

- Calling all beneficiaries who have had their coverage extended to verify their contact information. At least three, and often more, attempts have been or will be made to reach each of these beneficiaries.
- Opening an Address Update Hotline that beneficiaries can easily call to verify and update their contact information. DHS is promoting this through earned, organic, and paid media and social media.
- Requesting partners across the state share messaging about the importance of updating their addresses and contact information with DHS.
- Received approval for an (e)14 waiver from the federal government to allow the State to accept verified beneficiary addresses from managed care organizations, including the Provider-led Arkansas Shared Savings Entities (PASSE), without the need to do additional verification. The State also requested approval to accept United States Postal Service/National Change of Address data and verified addresses from Qualified Health Plans (QHPs) that provide coverage for Arkansas Health and Opportunity for Me (ARHOME) beneficiaries without the need for additional verification.

Nationally, the Centers for Medicare and Medicaid Services (CMS) estimates about 15 million individuals across the country will be disenrolled when the continuous enrollment condition ends and hopes that those who are no longer eligible will transition to other coverage such as Medicare, Marketplace, or employer-sponsored coverage and remain insured. Using historical disenrollment data in Arkansas for 2018 and 2019 (the most recent years before COVID), DHS estimates between 15 and 30 percent of the extended Medicaid population will be disenrolled during the unwinding. It's important to note here that right before and during the pandemic, Arkansas's minimum wage increased three times – to \$9.25 in 2019 to \$10 in 2020, and \$11 in 2021 – and would have resulted in a portion of beneficiaries becoming income ineligible for Medicaid programs. The State already is seeing this impact in the Supplemental Nutrition Assistance Program and expects this to impact eligibility for many beneficiaries.

With the work outlined in this plan, the State aims to protect the taxpayers, minimize coverage loss for eligible individuals, and support continuity of coverage for those who are no longer eligible. Arkansas will implement a state-based approach for renewals, redeterminations, and terminations that incorporates:

- Prioritization of those most at-risk of losing coverage, specifically those whose coverage has been conditionally extended due to the PHE
- Program-specific outreach aimed at preventing eligible individuals from losing coverage, especially more vulnerable populations
- Distribution of renewals based on how long it takes to complete the renewal process, the complexity of that process (i.e. need for medical or other determinations in addition to financial), and the size of the category of assistance populations (aligning category renewals for categories that have a natural fit such as ARHOME, ARKids, and Parent-Caretaker)



- Aligning renewals/re-determinations at a household level
- Sustainability of renewal schedule for the future and manageable workloads for staff

Arkansas built the renewal schedule using existing processes, such as sending renewal packets for individuals in long-term services and supports (LTSS) categories a renewal about 120 days before it is due and about 90 days in advance for all other categories. This is done because LTSS renewals are complex and require more than a simple financial determination. Medical records need to be collected and medical or level of care determinations need to be made. By putting LTSS renewals near the beginning of the unwinding period, we are ensuring adequate time for processing as well as time for intensive outreach to those groups. ARHOME, ARKids, and Parent-Caretaker categories of assistance will be among the first categories to begin renewals because of the sheer number of extended beneficiaries in those categories (over 300,000) and the timeframe by which the State must complete renewals. Outreach is described in more detail in the Population-Specific Outreach and Messaging sections of this plan.

Arkansas's state-based approach also incorporates specific requirements mandated by Act 780 of 2021 of the Arkansas General Assembly. Extended cases that have not had a re-evaluation in the last 12 months must be initiated and completed in six months. Regular renewals will continue during this time, though they may be staggered to ensure the workload is manageable and create an evenly distributed renewal workload for the future. Arkansas is mindful of CMS's concerns about initiating renewals for no more than 1/9 of total caseload in any given month. Renewals for groups that need to be handled over several months to accommodate the caseload recommendation, when possible, will be distributed based on current recertification date.

All renewals will be completed using Arkansas's new integrated eligibility system, Arkansas Integrated Eligibility System (ARIES), which evaluates beneficiary information against all categories of coverage and will flag when the beneficiary may be eligible for multiple categories. For example, if a child who is in the foster care Medicaid category also is eligible for CHIP, the system will take that into account during renewal and will move the child to the CHIP category if the child is no longer in foster care. This approach prevents disruption in coverage.

Renewals and re-determinations will be aligned and completed at a household level, meaning, for example, that if beneficiaries in a Medicare Savings category are in the same household as someone in TEFRA, the re-determination will occur when TEFRA cases are processed for renewal (see Appendix D for renewal schedule).

Although CMS guidance allows some flexibility to terminate coverage with advance notice without a redetermination for cases that have been extended for less than six (6) months, Arkansas will begin the termination process by initiating a renewal/re-determination for all individuals that have been extended during the PHE. Reasons for this methodology include:

- Making the process consistent for all
- Handling this process through renewal has the potential to ease the process for beneficiaries who can be renewed ex-parte
- The renewal process could help reduce the churn and workload of re-applications



- Notice language for those determined ineligible during the PHE explained to beneficiaries that they would be asked for updated information to re-determine their eligibility before closure is initiated.

Renewals that cannot be completed ex-parte will be mailed pre-populated renewal forms and given time to provide the information to complete the renewal determination.

Eligibility and Enrollment Operations

DCO will take lead on resolving pending eligibility and enrollment actions and resuming normal operations with support from the DHS offices of the Secretary, Information Technology, Chief Counsel, Appeals and Hearings, Legislative and Intergovernmental Affairs, and Communications & Community Engagement as well as other DHS divisions. In addition, vendors supporting DHS's integrated eligibility system, the State's Medicaid-related management dashboards, and the Medicaid Management Information System (MMIS) will support winddown efforts and will be key to ensuring Arkansas can transition to routine operations. The Division of Medical Services (DMS), with support from the divisions of Developmental Disabilities Services (DDS); Aging, Adult, and Behavioral Health Services (DAABHS); and Provider Services and Quality Assurance (DPSQA), and the offices of the Secretary and Legislative and Intergovernmental Affairs will take lead on the unwinding of rules, waivers, and rates when the PHE ends or when those flexibilities are set to sunset.

Eligibility and Enrollment Staffing

As of the end of December, DCO has just over 845 eligibility caseworkers processing applications, renewals, and changes. Like most states, Arkansas did experience a decline in the number of employees during the pandemic due to several factors, with April 2021 seeing the fewest number of eligibility workers (804). Though eligibility staff vacancies were an issue throughout much of the pandemic, the State has filled most positions. Recognizing a loss of staff, especially seasoned staff, and the need to get casework current before ending the continuous enrollment condition, DHS contracted with Deloitte and Maximus to provide contracted eligibility staff as mentioned above. Having those contractors working now will create a more seasoned and experienced staff when it is time to unwind. The State also will be monitoring daily the staff workload and productivity metrics to ensure the workload remains manageable. This will allow early visibility into whether casework is getting behind and if there is a need for additional or re-organized staff. In addition to the eligibility staff, DHS also contracted with the Arkansas Foundation for Medical Care (AFMC) to provide 30 staff to work the Update Arkansas Hotline. Accurate contact information will be critical to our success in keeping eligible individuals covered. Training and customer service are key elements within staffing, as having adequate staff is not helpful if the staff do not know how to perform the work or help beneficiaries. Training is provided when a worker comes on board and Zoom town halls have been held for DCO staff in all 75 Arkansas counties more than once to explain the unwinding, the importance of customer service, and what the ending of the continuous enrollment condition means for county office staff. Workers also will be provided a customer service toolkit, which includes scripts, frequently asked questions, and more.

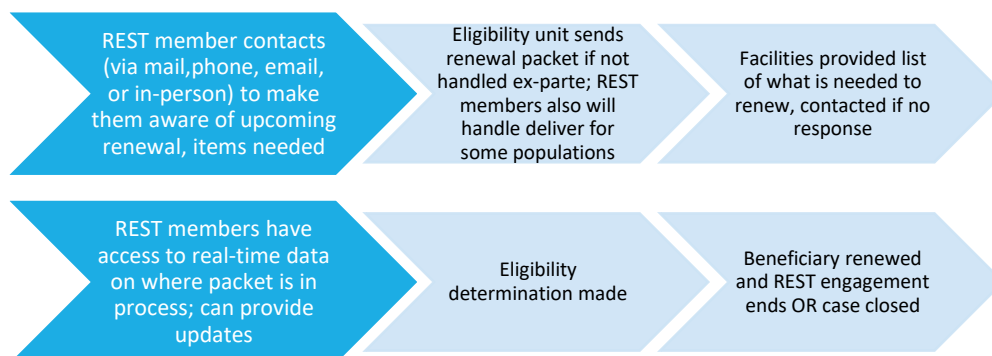


Safeguards

Ensuring eligible individuals keep their coverage – and that Arkansas Medicaid stops paying for ineligible individuals – during the unwinding is paramount. Safeguards have been or are being implemented to provide protection in the event of system or process error. Those include:

- Daily monitoring of filed appeals/requests for fair hearings by eligibility supervisors, who will review for – and address – administrative errors, including reinstating coverage so eligible beneficiaries will not have to go through the appeals process.
- Daily monitoring and tracking of call lines and agency social media accounts for trending issues that may signal a system problem that needs to be addressed.
- Providing benefits pending the outcome of a fair hearing request for LTSS categories without the need to specifically request extended benefits. Non-LTSS populations can request benefits pending an appeal.
- Providing 90-day retroactive coverage for certain populations.
- Transition period for LTSS beneficiaries found to be medically ineligible.

In addition to safeguards built into the eligibility and appeals processes, program staff will take ownership of those populations for the purposes of outreach and support to make sure beneficiaries understand that renewals are coming and what information they will need to provide for renewal. For some Medicaid programs, this is a new approach to renewals, and one we anticipate continuing beyond the end of the continuous enrollment condition. Their work and engagement will be in addition to any routine notices or electronic communications from DHS and any paid/earned outreach conducted by the DHS Office of Communications and Community Engagement. Staff will keep more vulnerable LTSS beneficiaries updated throughout the renewal process and provide an enhanced level of support to guide them and to keep eligible individuals covered. To do this, each program area is creating Renewal and Education Support Teams (REST) in each specialty program area (e.g. ARChoices, Community and Employment Supports waiver, etc.) that will engage beneficiaries before renewals begin and continue to provide outreach and support throughout the process. This will be done using existing staff in most cases who will be diverted to these tasks during the unwinding. A more detailed breakdown of the work of the renewal and education support teams is below by population. In the general, the CREST process will be as follows, with some variations depending on the population being engaged.





Up-to-Date Contact Information Efforts

Arkansas Medicaid has implemented a comprehensive, multi-strategy plan for confirming and updating contact information for all clients who will be sent renewal packets as part of the unwinding. These approaches, which are ongoing, represent a good faith effort on the part of Arkansas Medicaid to update contact information for clients who will be impacted by the unwinding. Those efforts include:

- Creating the Update Arkansas hotline, which clients can call to update their address, phone number, and email address. Hotline staff also are attempting at least three outbound calls to each client who will receive a renewal packet during the unwinding. To date, hotline staff have updated or confirmed contact information for over 140,000 clients.
- Continuing to accept address, phone number, and email address updates at our county offices (in all 75 counties), via our online citizen portal, and via the mail.
- Using reliable data sources, including the National Change of Address database to find client addresses that are more current than what we have on file.
- Receiving e(14) waiver approval to accept verified contact information from contracted managed care organizations, the PASSE programs, and the QHPs that serve ARHOME clients.
- Creating the Update Arkansas outreach campaign, which includes organic, earned and paid media; social media, radio advertising, and digital messaging in medical and state offices encouraging people to update their contact information; an online toolkit with shareable materials promoting the campaign available in English, Spanish, and Marshallese.
- Engaged an advisory panel of DHS Medicaid clients to keep them apprised of the need to have clients update their contact information and to help spread the word.
- Hosting Zoom town halls with providers, medical staff, and other stakeholders who interact regularly with our clients to ask them to share the Update Arkansas campaign materials and messaging with their patients/clients.
- Using our provider outreach team to educate providers about the importance of asking their patients/clients to update their contact information and respond to a renewal if they get one.

Returned Mail

To comply with the requirements of the federal Consolidated Appropriations Act, 2023, the eligibility system will not close cases where the mail was returned due to a bad address until the State has taken “a good faith effort to contact the individual using more than one modality.” Because states were not given much time to implement system changes, Arkansas has implemented a short-term process to ensure these cases are not closed without good faith efforts to use additional modalities. To initiate that process, clerical staff will scan returned mail, which will trigger a returned mail “task” in the eligibility system. Every evening, the eligibility system will scan for all cases with new returned mail tasks and send email, text, and/or online citizen portal alerts to clients with returned mail, based on the information we have in our system (i.e. an email address, cell phone number, or whether they have a citizen portal account).

In addition, staff will manually verify that the address where the notice was sent is correct and attempt to contact client via mail or other modalities. This process was put in place in February 2023 to ensure compliance.



Outreach Tools and Feedback

The State already has started the first phase of its comprehensive, multi-channel outreach and engagement plan. The outreach plan, which leverages providers, stakeholders, media, and other channels to get messages out, is closely tied to the distribution of work necessary to meet the re-evaluation requirement of Act 780 of 2021. To begin, DHS has:

- Conducted a focus group with Medicaid beneficiaries to ensure outreach materials are easy to understand and convey a sense of urgency and call to action. Materials were updated based on feedback.
- Developed a customer service toolkit that provides county office and call center staff clear messaging and guidance on how to handle different situations.
- Developed beneficiary, provider, and stakeholder toolkits that include print materials, social media materials, call center scripts, and website and email content in English, Spanish, and Marshallese.
- Ensured official notices are easy to understand and in plain language.
- Sought feedback on the unwinding from the Arkansas Medicaid Client Voice Council on both outreach materials and outreach approach. We will continue to work closely with the Council and to seek their valuable input throughout this process and beyond.

Population-Specific Outreach and Distribution of Work

The distribution of work over the unwinding period will focus on the needs of each population and the resources available within DHS and through its partners. Information about traditional and social media outreach can be found in the “Messaging and Elements of Communication Plan.”

HCBS for Beneficiaries who are Aging or Physically-Disabled (ARChoices and PACE)

As of Dec. 28, 2022, 2,880 individuals in the ARChoices category and 138 in Program of All-Inclusive Care for the Elderly (PACE) have had their coverage extended. Because these types of renewals are more complex than a traditional Medicaid renewal, the State initiates a renewal 120 days before it is due. The renewal will request a response within 60 days. If the beneficiary does not respond with a completed renewal packet by then, DHS will send a second “reminder” letter with a final due date.

DAABHS has tapped its field nurses, with whom beneficiaries are already comfortable and familiar, and other staff across the state to talk with people enrolled in ARChoices who have been extended and those coming up for regular renewal about the importance of responding to upcoming renewals. Renewal packets were hand-delivered to all extended beneficiaries in fall/winter of 2022 in an effort to reduce the number of “extended” beneficiaries.

For the PACE program, DAABHS is providing a list of extended beneficiaries to the three PACE providers in Arkansas and asking that the providers engage those they serve about responding to renewals and keeping their contact information current with DHS. These lists will be provided monthly until we are 60 days out from the unwinding date, at which time lists will be sent weekly. REST members will monitor when renewal packets are sent and whether beneficiaries have responded, following up via telephone and/or email with providers about those who have not returned their renewal packets.



Additionally, DAABHS is sharing renewal and address update messaging with the State’s Area Agencies on Aging and senior centers during regular calls with those entities and asking them to share this important information with everyone they serve.

ARHOME (Medicaid Expansion Population)

As of **Dec. 28, 2022, 128,881** beneficiaries in this Medicaid category have had their coverage extended due to the continuous enrollment condition. DMS will oversee outreach efforts for this population, which gets renewal packets mailed 90 days before they are due, if they are not approved through the ex parte process. ARHOME is the State’s Medicaid expansion population, and most beneficiaries are served through private, qualified health plans (QHPs). DMS has provided the QHPs with lists of their enrollees who are extended and asked those plans to conduct outreach about the importance of updating their addresses with the State and responding to renewals (further information about the outreach can be found in “Messaging and Elements of Communication Plan”). Those lists are being provided monthly, and the frequency will increase to weekly 60 days before the continuous enrollment condition is set to end.

In addition, DMS is running lists of extended beneficiaries who use non-emergency transportation (NET), which this population is eligible to use, and sending those lists to the NET providers. NET providers are being asked to engage their riders about address updates and responding to renewals. This is particularly important because the small portion of ARHOME beneficiaries who use NET frequently rely on the program to get to medical appointments, making it critical that eligible beneficiaries keep their coverage so they can get to doctor appointments via NET. NET providers have been asked to provide their outreach plans to the State for review and feedback. Pharmacies, hospitals, providers, and related associations also are being or have been sent specific messaging and calls to action.

The Arkansas Insurance Department navigators will be available to answer state-specific questions from those who have become financially ineligible for ARHOME about transitioning to a market-place plan.

ARKIDS A & B, Newborns, Parent-Caretaker Relative, and Pregnant Women

As of **Dec. 28, 2022**, there were **216,937** beneficiaries in these categories who have had their coverage extended. DMS also will work to coordinate outreach for these populations. Renewals are sent 90 days before they are due, and a reminder notice is sent after 30 days. DMS will send lists of extended beneficiaries and a call to action to engage these individuals about updating their addresses and respond to renewals to their:

- Assigned primary care physicians monthly (moving to weekly if needed).
- Dental managed care organizations monthly
- NET providers monthly

In addition, starting in June 2022, DMS partnered with the Arkansas Chapter of the American Academy of Pediatrics, the Arkansas Pharmacy Association, the Arkansas Medical Society, and the Arkansas Hospital Association, which are sharing outreach materials with members and continuously engaging members about the importance of this effort. Provider outreach teams AFMC will continue to host



periodic webinars about the ending of the continuous enrollment condition and will engage provider staff during regular in-person visits.

Outreach materials also will be provided to all local Arkansas Department of Health units, which serve a significant number of pregnant women and new mothers, and the Women, Infants, and Children (WIC) program offices. DHS also will share outreach materials with the child care centers it licenses and ask that the information be provided to families. Information also will be shared with libraries and in-state revenue offices (where driver's licenses are obtained). The Arkansas Department of Education has agreed to partner with DHS to engage local school districts and school nurses.

Lastly, DHS will conduct extensive outreach efforts aimed at this population by engaging community-based organizations across the state that work directly with low-income children and families. These community partners will be asked to partner with the State in two ways and will be provided mini-grants to support their work. These organizations can serve as partners that simply share DHS messaging with the people they serve or they can become more proactively involved by assisting beneficiaries who need help responding to their renewals. More information about this effort can be found in the "Messaging and Elements of Communication Plan" section.

Most of the work noted above related to the ARKids, Newborn, and Pregnant women categories started in Spring 2022 and will continue in some form throughout the unwinding. DMS will send informational postcards to beneficiaries to let them know what actions they should take to renew. Providers will be asked to send targeted and specific patient communications after renewal packets are mailed out in an effort to increase the number of beneficiaries who return requested information.

Assisted Living and Skilled Nursing Facilities

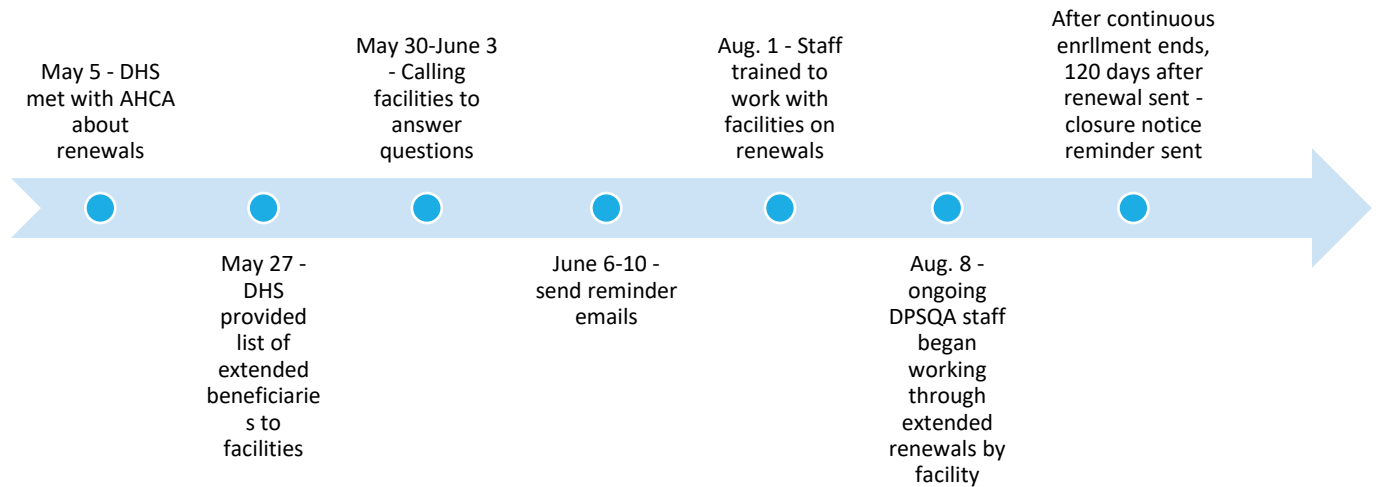
As of Dec. 28, 2022, 267 beneficiaries in the Assisted Living Medicaid category have had their coverage extended. Because these types of renewals are more complex than a traditional Medicaid renewal, the State initiates renewals 120 days before they are due. The initial renewal will request a response within 60 days. If the beneficiary does not complete the renewal process by then, DHS will mail a second "reminder" notice with a final due date.

DAABHS is working directly with Assisted Living providers by providing each with a list of beneficiaries who have been extended so that they can assist them in returning their renewals as soon as possible. This work began in August 2022 in an effort to reduce the number of "extended" individuals in this category, and the numbers have gone down. These facilities and providers have been asked to work with their patients to respond to renewal packets. DAABHS also has engaged the Assisted Living Association and asked that it share outreach material and calls to action with its members.

The State, through the DHS Division of Provider Services and Quality Assurance (DPSQA), also is working directly with skilled nursing facilities to support renewals for this population, and thus, will not have a CREST. This is a new and more hands-on approach for DPSQA as it has previously not been involved with eligibility-related efforts. The process it is using is outlined below. As of Dec. 28, 2022, 4,058 nursing home patients in this Medicaid category have had their coverage extended. The State also initiates renewals for this population 120 days before they are due and issues reminder notices like other long-



term services and supports categories. To mitigate the risk of closure for eligible beneficiaries in nursing homes, DPSQA is working with the Arkansas Health Care Association to reinforce messaging about the importance of renewals.



After the continuous enrollment condition ends and DHS determines a beneficiary’s coverage should be closed, that person has a right to appeal within 30 days. Beneficiaries in this category who file a request for a fair hearing automatically will have their coverage continued until there is a hearing decision.

Autism Waiver, Community & Employment Support Waiver, and TEFRA

As of Dec. 28, 2022, there were 3,479 beneficiaries extended in these Medicaid categories. The DHS Division of Developmental Disabilities Services (DDS) will oversee efforts to ensure eligible individuals in these populations remain covered. Already, DDS works directly with intellectual and developmentally disabled beneficiaries and potential beneficiaries to walk them through the process of getting all the documents needed to apply. That personal support and engagement will expand to those who need to renew as part of the outreach efforts tied to the end of continuous enrollment. In December 2022, DDS mailed postcards to extended individuals encouraging them to update their contact information. A second post card will be mailed one month prior to renewals being initiated reminding beneficiaries and their families about the importance of responding to renewals requested documents and records. The DDS REST members will make calls to families that have not responded to renewal packets or who still need to provide information so that renewals may be completed.

DDS also will give providers outreach materials and messaging they can use in offices and on social media.

Foster Care, Guardianship, and Adoption

The DHS Division of Children and Family Services (DCFS) will be responsible for overseeing efforts to ensure individuals in the foster care category maintain coverage, if still in care, and that individuals in the other categories are aware of the importance of updating their addresses and responding to renewals, and know how to apply for different coverage, if needed. As of Dec. 28, 2022, there were



4,536 children and teens who had been extended in these categories. It's important to note that the State's eligibility system places beneficiaries in the best coverage category. Those in the foster care category, for example, may no longer be in care, but because moving them to another category would be considered lesser coverage, they remain in that category until the unwinding. Many also are eligible for ARKids A or B and will maintain that coverage and have their foster care Medicaid closed. For those who remain involved with DCFS, caseworkers have been talking with parents/guardians during regular visits to make them aware of the need to renew or apply for new coverage and will assist them with the paperwork, if needed. As a result of this effort, DCFS is talking with and assisting families with renewals and coverage as part of their regular work processes to improve continuity of coverage even beyond the unwinding.

For the guardianship, adoption, and former foster care categories, staff will use contact information on file to attempt to contact the families about upcoming renewals. For those they cannot reach, staff will work with DCO to attempt a digital address match using a new system procured for that purpose. Letters will then be sent to the addresses obtained during that match in an attempt to reach families before cases are closed.

Other Categories of Assistance

DMS will take the lead on other adult Medicaid categories, such as the Medicare Savings Programs, spend down, medically needy, and workers with disabilities. As of Dec. 29, 2022, there were 54,953 aged, medically-complex or disabled beneficiaries in these categories who have been extended. DMS is cross-matching the list with lists of those who use Medicaid NET or dental managed care. Almost all the beneficiaries in these populations do use at least one of these services. NET and dental managed care organizations will be given lists of their clients in these categories who are extended and will be asked to engage those individuals about updating their addresses and responding to renewals. DMS also will share messaging with the Dual-Eligible Special Needs Plans that work with the Medicare population. These organizations will be given DHS's provider outreach toolkit to support their efforts with this population. Lists will be provided monthly.

PASSE

DMS and DAABHS will work together to oversee efforts to ensure individuals in the Provider-led Arkansas Shared Savings Entity (PASSE) Medicaid program know about the importance of responding to renewals and complete their independent assessment, which determines beneficiary's level of service. As of Dec. 27, 2022, 14,229 beneficiaries in this program have had their coverage extended. These beneficiaries come from multiple Medicaid categories and have high-cost, high-need behavioral health and/or intellectual or developmental disabilities. Those in a Modified Adjusted Gross Income (MAGI) category will have their renewals initiated 90 days before they are due. Renewals will be initiated 120 days before they are due for non-MAGI categories. For address update and renewal-related outreach, DMS and DAABHS will:

- Ensure PASSE care coordinators work with members to update their addresses with Medicaid and schedule independent assessments.



- Send a postcard to beneficiaries with information about when the ending of the continuous enrollment condition and what they need to do to keep PASSE coverage.
- Train a group of staff to reach out to PASSE beneficiaries and their families and help them through the process of keeping Medicaid and PASSE coverage.
- Dedicate a unit within DMS to work with the PASSEs to target the most vulnerable beneficiaries (those with highest tiers and using the most services) to help them through the process so they do not have a lapse in coverage, and thus, the potential for a significant behavioral health issue.

Because this program also requires an independent assessment, DMS and DAABHS also will conduct a targeted outreach effort to get beneficiaries needing assessments seen. That effort will include:

- Ensuring our assessment vendor goes to facilities and other provider locations to conduct assessments and makes at least three attempts to contact those needing assessments.
- Giving providers lists of individuals who have been extended and/or who need an independent assessment and asking the PASSEs to contact their members.

DMS also is exploring ways to make completing assessments easier (including using telephones to complete assessments and allowing for a case review to determine if assessment is needed).

Messaging and Elements of Communication Plan

There are two related but distinct phases to the communications plan. Phase 1 (*Update Arkansas*) focuses on giving beneficiaries the tools to update their contact information (mailing address, phone number, and email) quickly and easily so that important information (like Medicaid renewal packets) reaches them. Phase 2 (*Renew Arkansas*) is designed to encourage beneficiaries to check their mail for, complete, and return Medicaid renewal packets, if received.

Every element of the communication and outreach plan is built around the following key messages to people enrolled in Medicaid:

- **Update your contact information:** Arkansas will soon be required to review Medicaid and ARKids eligibility for people whose coverage was extended due to the COVID-19 public health emergency. Plan ahead and update your contact information now.
- **It's time to renew:** Renew your Arkansas Medicaid or ARKids coverage now. Here's what you need to do to keep your coverage.
- **If you lose Medicaid, here are your coverage options:** If you are no longer eligible for Arkansas Medicaid or ARKids, there are other low-cost health insurance options. Financial help is available to lower costs. Visit myarinsurance.com to find a plan.



Core Audience(s)	Key Messages	Communication & Engagement Methods and Tools	Communication & Engagement Partners
<p>Medicaid and ARKids benes./caregivers</p>	<ul style="list-style-type: none"> • Update your contact info • It's time to renew • If you lose Medicaid, here are your coverage options 	<ul style="list-style-type: none"> • Web • Social media • Paid media • Bene. Toolkit of printable/ shareable materials • Direct phone calls to benes. (outbound) • Call center and local DHS county offices (inbound) • E-mail • Direct mail • Update chatbot on website • Stakeholder meetings 	<ul style="list-style-type: none"> • Legislators • QHPs & Managed Care Organizations (MCOs) • Providers/health care facilities/ clinics • Local DHS county offices digital bulletin boards (DBBs) • Local health units (DBBs) • Community-based organizations • Other state agencies • Media outlets • Churches/Faith-based organizations
<p>Providers/health care facilities/clinics</p>	<p>Your patients trust you and the information you give them about their health. This position of trust gives you a unique opportunity to help your patients see and act on this important PHE unwinding messaging.</p>	<ul style="list-style-type: none"> • Provider Toolkit of printable/ shareable materials to provide to benes. • Lists of their patients who were extended due 	<ul style="list-style-type: none"> • AFMC as part of provider education work • Provider organizations that can disseminate to members



Core Audience(s)	Key Messages	Communication & Engagement Methods and Tools	Communication & Engagement Partners
		to the PHE (based on claims and PCP assignment data) <ul style="list-style-type: none"> • Zoom webinar/stakeholder meetings 	
QHPs/ARHOME Plan Carriers/PASSEs(MCOs)/Dental MCOs, NET providers	Your members trust you and the information you give them about their health. This position of trust gives you a unique opportunity to help your members see and act on this important PHE unwinding messaging.	<ul style="list-style-type: none"> • Toolkit of printable/shareable materials to provide to benes. • Lists of their patients who were extended due to the PHE (based on plan assignment data) • Stakeholder meetings 	<ul style="list-style-type: none"> • Plan communication teams • NET provider leadership
Call Center/DHS local county office staff/Client assistance/Constituent services	Here are responses to common questions you may get from Medicaid benes. with questions about the PHE unwinding messaging.	<ul style="list-style-type: none"> • Scripted FAQ-type messages shared with staff. • DCO town halls to walk through plan/expectations 	<ul style="list-style-type: none"> • Call Center Staff • DCO staff • DCO client assistance staff • Leg. Affairs constituent services staff
Media	During the public health	<ul style="list-style-type: none"> • Pen and pad 	<ul style="list-style-type: none"> • Statewide TV stations



Core Audience(s)	Key Messages	Communication & Engagement Methods and Tools	Communication & Engagement Partners
	<p>emergency, Arkansas was not allowed to remove individuals from the Medicaid rolls. People who get Medicaid need to take steps now to make sure they get important information they will need to renew their coverage.</p> <p>Arkansas will send out renewals to individuals who appear to be no longer eligible based on the information we have. Coverage will be terminated if the information is correct or if the individuals do not respond to a request for more information in the time allowed.</p> <p>We will not cancel or reduce coverage without asking those calling for updated information. We need your help to make this a smooth process.</p>	<p>session to invited media members and the Governor/ Secretary</p> <ul style="list-style-type: none"> • Press release • Graphics • Key Messages • Morning/ afternoon TV show appearances 	<ul style="list-style-type: none"> • Statewide newspapers • Independent reporters • Local radio stations
<p>Sister Government Agencies (i.e., Health, Division of Workforce Services, Arkansas Department of Corrections Division of Community Corrections)</p>	<p>During the public health emergency, Arkansas was not allowed to remove individuals from the Medicaid rolls. People who get Medicaid need to take steps now to make sure they get important information they will need to renew their coverage.</p> <p>Arkansas will send out renewals to individuals who appear to be no longer eligible based on the information we have. Coverage will be terminated if the information is correct or if the individuals do not respond to a request for more information in</p>	<ul style="list-style-type: none"> • Key messages • Responses to common questions if asked • Toolkit of printable/ shareable materials • Stakeholder calls • Community Corrections to text their clients • Health to text their patients 	<ul style="list-style-type: none"> • Communications teams at each agency



Core Audience(s)	Key Messages	Communication & Engagement Methods and Tools	Communication & Engagement Partners
	<p>the time allowed.</p> <p>We will not cancel or reduce coverage without asking those calling for updated information. We need your help to make this a smooth process.</p>	<ul style="list-style-type: none"> • ADE to publish a commissioner's memo and share materials with districts, school nurses, and counselors. 	
Community-based organizations	<p>During the public health emergency, Arkansas was not allowed to remove individuals from the Medicaid rolls. People who get Medicaid need to take steps now to make sure they get important information they will need to renew their coverage.</p> <p>Arkansas will send out renewals to individuals who appear to be no longer eligible based on the information we have. Coverage will be terminated if the information is correct or if the individuals do not respond to a request for more information in the time allowed.</p> <p>We will not cancel or reduce coverage without asking those calling for updated information. We need your help to make this a smooth process.</p>	<ul style="list-style-type: none"> • Key messages • Responses to common questions if asked • Toolkit of printable/ shareable materials • Stakeholder calls 	<p>Community-based organizations across the state including food pantries, ARIES community partners, and other organizations that work directly with low-income families.</p> <p>Grant opportunities available to support their outreach efforts and efforts to help beneficiaries complete renewals online.</p>
Stakeholder engagement	<p>During the public health emergency, Arkansas was not allowed to remove individuals from the Medicaid rolls. People who get Medicaid need to take</p>	<ul style="list-style-type: none"> • Monthly Zoom town halls with stakeholders across the 	<p>Medicaid Client Voice Council</p> <p>Any stakeholder</p>



Core Audience(s)	Key Messages	Communication & Engagement Methods and Tools	Communication & Engagement Partners
	<p>steps now to make sure they get important information they will need to renew their coverage.</p> <p>Arkansas will send out renewals to individuals who appear to be no longer eligible based on the information we have. Coverage will be terminated if the information is correct or if the individuals do not respond to a request for more information in the time allowed.</p> <p>We will not cancel or reduce coverage without asking those calling for updated information. We need your help to make this a smooth process.</p>	<p>state (e.g. food banks, advocacy organizations, hospital foundations, etc.)</p> <ul style="list-style-type: none"> Public toolkit that includes social media materials, digital materials, and print materials. 	<p>organization that works with, serves, or advocates on behalf of children, families, or adults</p>

Fair Hearings Requests

As of **Dec. 29, 2022**, no fair hearing requests in Arkansas are currently more than 90 days old, which puts the Department in a good position as we prepare for the end of the continuous enrollment condition. The DHS Office of Appeals and Hearings (OAH) will take lead on monitoring, responding to, and processing fair hearing requests. OAH has reviewed historical and other data and estimates 3,500 Medicaid fair hearing requests a month as a result of the unwinding – in addition to the 700 received monthly today. To accommodate the additional workload, OAH is leveraging temporary staffing contractors to add up to 25 clerical staff, up to seven additional administrative law judges, and up to 14 additional hearing officers, depending on need and volume. OCC also is contracting with additional attorneys and re-assigning workloads to handle the subset of requests that require the Department to be represented by an attorney. The effort to identify the temporary support is already underway with the plan for those individuals to be fully trained and ready to operate prior to the unwinding beginning.

Leadership from the offices and divisions impacted have been meeting to evaluate needed operational changes and are moving forward with some changes, including:

- Adding records coordinators to the programs to help reduce the time it takes to obtain records required for hearings



- Adjusting the hearing scheduling process so that an attorney works with the same judge on the same type of appeals on a given day to reduce transition times
- Automatically scheduling all hearings as phone hearings with the option for an in-person hearing.
- Cross-training staff to help address workload increases.
- Using an electronic appeal process to cut down on the need for paper records and manual processes.
- The State will monitor daily the number of appeals coming in as part of our Medicaid PHE Control Center daily meetings and make workflow adjustments as needed. The only system change required at this time is adding a field to our database that automatically captures whether someone's benefits are continuing during the request period since that is currently a manual process.

Regular & Sustainable Eligibility Operations

The State will adjust regular renewal timelines to spread out the work following the unwinding and set the schedule so that it is sustainable in the long-term. Arkansas also is considering operational and policy changes necessary to implement ex-parte renewals for the Medicare Savings Group (QMB, QI, SLMB), though it is not feasible to implement before the continuous enrollment condition ends.

Systems Readiness

It's important that all systems that will be used during the unwinding are ready and that DHS identifies any potential system issues that could cause erroneous closures. To that end, the State and its ARIES vendor are testing 500 scenarios in advance of the unwinding that will ensure:

- Ex-parte functionality is working properly
- Notices that are triggered are correct
- Transitioning beneficiaries between categories is seamless
- Moving data from ARIES to the Medicaid Management Information System (MMIS) is streamlined

In addition, the MMIS vendor is meeting with DMS to ensure the system is ready to end any flexibilities that are set to expire at the end of the PHE. DHS leadership and division staff also will be meeting regularly with system vendors to ensure they are prepared for the unwinding and have an avenue to report back any issues that may arise.

Unwinding Emergency Waivers, Rules, and Rates

Arkansas implemented a number of flexibilities in the form of waivers, rules, and rate adjustments during the PHE that will require action following the termination of the emergency declaration, which has been de-coupled from the ending of the continuous enrollment condition. Some flexibilities will remain in place permanently and others will expire. All flexibilities implemented by Arkansas during the PHE are being tracked separately from this plan. Unwinding these will require changes in the State's MMIS. The State and its vendor, Gainwell, have worked together to develop a plan to unwind the



flexibilities that will expire with an estimated timeline of four weeks to make and test system changes before they are moved into production.

Monitoring Unwinding and Beyond

Though the unwinding of the continuous enrollment condition presents an unprecedented challenge, it also is an opportunity for Arkansas and other states to implement enhanced customer service and monitoring initiatives that will live beyond the unwinding. In addition to the enhanced support and engagement by program staff that will continue, DHS also has created a Medicaid Control Center by which leadership will be able to monitor all aspects of Arkansas Medicaid including initial applications, renewals, timeliness, provider enrollment, and much more. The goal of the Control Center, which is being built with the support of our vendor Deloitte, is for the DHS Secretary and her leadership team to have the capacity to look at key metrics and data across Medicaid programs – eliminating silos that can mask developing issues and problems and giving greater visibility into all aspects of Arkansas Medicaid operations.



Appendix A

State Readiness and Risk Assessment

With the issuance of the [State Health Official letter #22-001](#) and unwinding assessment and planning template, DHS began in the early Spring of 2022 a coordinated and comprehensive risks and readiness assessment for eligibility and enrollment based on specific risks identified by CMS. Key takeaways from that assessment are that:

- The State’s integrated eligibility system has been designed to include triggering redeterminations on all individuals whose coverage was extended due to the PHE. That will be tested in advance of the State beginning the unwinding period. The system can stagger and revise renewal dates.
- Any known needed eligibility and enrollment system changes are complete, and the team is developing a circuit-breaker process in the event we need to make a change or stop a process once the unwinding begins.
- All Medicaid eligibility notices have been reviewed for accuracy, clear action steps, and plain language and any needed updates have been made.
- The State has a comprehensive unwinding plan, parts of which already have been implemented, and the remaining elements are ready to launch.
- The State needed to increase the number of contracted eligibility staff to ensure it could manage the workload before and during the unwinding period. Most of the staffing is in place, either through the State or vendors, and hiring is continuing.
- The State needs to increase the number of legal and clerical staff to handle the associated workload related to fair hearing requests. Procurement work has begun to fulfill this need. The additional support should be identified in June 2022.
- The State will be conducting an initial address verification match with an outside vendor to improve the accuracy of contact information prior to renewals being mailed.
- The State needs a comprehensive monitoring process to ensure the unwinding is going as planned and that will identify issues quickly. The State is building out a PHE Medicaid Control Center that will be used to monitor data and is planning daily meetings with key staff and vendors to help with monitoring and implementation of quick solutions.
- There are no fair hearing requests that are more than 90 days old.

Readiness

The State has outlined important efforts it will be monitoring in advance of the unwinding. Completing all of these items will put the State in the best position as unwinding begins.

Milestone	Status
Eligibility casework current for Medicaid and SNAP	Ongoing
All SNAP cases added to our new eligibility system (ARIES) is complete	Completed early May



Milestone	Status
Operational and monitoring reports (accurate and ongoing)	In progress
Population-specific plans	Complete
System review	Ongoing
Medicaid Control Center Operational	In process
Address calls complete	First round complete
Unwinding plan approved by Governor; legislators briefed	Gov. approved; still need to meet Legislators
Medicaid Client Voice Council briefed, given opportunity for feedback; beneficiary focus group completed	Complete
County office staff trained	Complete
Communications & engagement plans developed and ready for implementation	Complete
Trained contractor capacity for: <ul style="list-style-type: none"> ○ Eligibility work ○ Unwinding support ○ Data support ○ Fair hearing request support ○ Beneficiary support ○ Independent assessments (for applicable medical portion of eligibility) 	Ongoing

Risks and Mitigation Plans

Part of the assessment outlined in the unwinding template included looking at risks, assessing the likelihood of the risk happening (low, moderate, high) and ways to mitigate those risks. Below are the seven risks identified and the State’s mitigation plans.

Risk 1: Inappropriate coverage loss among eligible individuals due to procedural or administrative reasons.

The State considers inappropriate coverage loss among eligible individuals due to procedural or administrative reasons as a moderate risk for Arkansas. Arkansas has created a Medicaid PHE Unwinding



Control Center that will monitor daily data related to the renewal process to identify any potential procedural or administrative issues that may be causing inappropriate closures. This Control Center will include people from multiple Medicaid programs and IT system staff, as well as constituent services, client assistance teams, and vendors integral to those processes.

In addition, Arkansas already employs certain mitigating strategies and is planning to implement others (as outlined in the plan above). Arkansas already:

- Leverages several key data sources to mitigate this risk, including quarterly wage match, new hire, SNAP and TANF as well as reasonable compatibility data (10 percent threshold) for MAGI populations. Those processes are automated.
- Conducts ex-parte renewals. The State uses reasonable compatibility data (10%) for income for MAGI populations. The State also uses pre-populated renewal forms consistent with federal requirements for those who must be mailed a renewal notice, and those forms have been reviewed for plain language.
- Ensures Arkansans can submit information and/or documents via mail, online, phone, and in-person. Beneficiaries can upload documents in multiple forms (PDF, JPEG, etc.) from their phones.
- Created a specialized unit to handle more complex renewals such as those for people seeking Long-Term Services and Supports and one for TEFRA coverage.
- Appeals monitoring every weekday to identify any potential administrative or system trending issues and address them without the need for a fair hearing.

Risk 2: Inappropriate coverage loss among eligible individuals due to being unable to reach enrollees

The State considers this a high risk given that eligible individuals may not have contacted DHS to provide accurate contact information since the pandemic began but continuing to process renewals and changes during the PHE did help the State maintain connection to many. The State's outreach and engagement plan (outlined in Outreach, Communication, and Engagement section) will help mitigate this risk. Additionally, Arkansas has taken a significant number of steps to address this, including:

- Establishing a call center in March 2022 with 30 staff who are conducting outbound calls to beneficiaries asking if their contact information is correct and updating that when needed. Center also accepts inbound calls and is being promoted heavily (paid and unpaid) as part of outreach efforts.
- Conducting an address verification match through a vendor prior to beginning the unwinding process to help improve the accuracy of the contact information DHS has.
- Encouraging beneficiaries to update their contact information online and to sign up for text and email alerts while there.
- Program staff also are reaching out to the most vulnerable populations that have been extended due to continuous enrollment to ensure they update their contact information and are aware of upcoming renewal.
- Adding language to every eligibility/enrollment notice reminding beneficiaries to update their contact information.
- Through a secure process, giving providers lists of their patients at-risk of losing coverage so the



providers can do targeted outreach and encourage action. Providers will be given scripts, fliers, social media graphics, website content, and other appropriate outreach material to assist in this effort.

- Engaging our Medicaid Client Voice Council to get feedback on our overall and outreach plans and guidance on ways that beneficiaries liked to be communicated to, and to find out what they are hearing from people they know in their communities.
- Working with MCOs, PASSEs, and QHPs to develop drawings for incentives of nominal value for beneficiaries who update their contact information.

Risk 3: Consumer confusion about the steps and critical deadlines to retain coverage

The State considers confusion over actions needed and deadlines to meet a low to moderate risk given the work we have already done to review and revise all Medicaid notices so that they are easier to understand, include clear action steps, and are written in plain language. The biggest factor is having updated contact information, so they get the information we have that explains actions and deadlines. Other steps Arkansas has taken to mitigate this risk include:

- Allowing providers to bill for interpretation services and use barcode technology to make processing documents easier.
- Building online portal accounts so they show renewal status and action steps that need to be taken. They also allow for online uploading of documents, including in picture or PDF format.
- Providing outreach materials, notices, interpreter, and call center support for limited English speakers and people with disabilities or who need large print materials. DHS also has begun advertising bilingual skills as preferred qualifications for eligibility workers and clerical staff. All outreach materials have been translated into Spanish and Marshallese.
- Establishing a process for trained community partners to assist people with online applications, renewals, and changes.
- Having a robust consumer assistance program that includes both vendors and DHS staff who are provided training and scripts to ensure consistent messaging and action steps. Scripts and FAQs are in development and staff will be provided training prior to the unwinding starting.

Risks 4: Gaps in coverage for individuals who are no longer eligible for Medicaid or CHIP.

The State considers gaps in coverage for people who are no longer eligible a moderate risk. (Note that Arkansas's eligibility unit, Medicaid, and CHIP are all under one umbrella agency). The State already transfers information of people found ineligible for Medicaid to the Marketplace in compliance with federal law, including the latest contact information the State has. The State also has conducted extensive testing (stubs and sample loads, interface, inbound/outbound transfers, etc.) with the Marketplace to ensure data is seamlessly transferred from ARIES. This is done routinely when system enhancements are released and during regular maintenance of the system. In addition, the State monitors this process for issues. Feedback is provided to the Marketplace if issues arise.

To further mitigate this risk, the State plans to:

- Add information to call centers scripts about continuity of coverage and what people can do if



they are no longer eligible for Medicaid. This is planned for May 2022.

- Review and revise notices (as needed) to explain account transfer processes and next steps.
- Work with other State agencies and initiatives (e.g. Division of Workforce Services and Arkansas Ready for Life) to identify processes to connect individuals to employment opportunities that may assist with the transition to employee-sponsored coverage.

Risk 5: Insufficient and over-burdened workforce to resolve pending E&E actions and complete routine work

The State considers having insufficient or over-burdened staff a low risk as we have already contracted with two vendors to add approximately 700 eligibility staff to help with the unwinding. Because the state had a backlog and engaged these staff in early calendar year 2022, these contract staffers are already trained and accustomed to the State’s eligibility system and processes. Still the state has or is taking steps to mitigate this risk. DHS already:

- Conducts renewals for all household members at the same time, aligns Medicaid and SNAP renewals, and leverages SNAP data.
- Created universal caseloads so that the work is distributed throughout the state rather than over-burdening certain offices. It’s important to note that Arkansas is legally prohibited under Act 780 of 2021 of the Arkansas General Assembly from becoming an eligibility determination state.
- Identified staff to support unwinding efforts, including a team in the Secretary’s office to monitor all aspects of the plan.
- Created a salary ladder that provides market rate salary increases when staff achieve training and proficiency in Medicaid, SNAP, and TANF eligibility processing and a higher rate of pay for complex case work, such as LTSS eligibility and certain certifications. High-achieving staff also can be financially rewarded during annual employee evaluations.
- Added ability for contract staff to do data entry for cases they cannot make determinations on to free up time of determination staff.
- Created online help tools and updates around eligibility manuals for staff, including for policy or workflow changes. DHS will ensure that changes and processes also are communicated to MCOs, QHPs, providers, and stakeholders in advance of the unwinding.

Risk 6: Lack of timely information to conduct appropriate oversight and course correct as issues arise

The State considers lack of timely information to conduct appropriate oversight and course correction a low to moderate risk. To mitigate this risk, DHS is/has:

- Created a central team responsible for monitoring all aspects of the unwinding. That team will coordinate daily oversight meetings to look at central pieces of the plan and data as well as smaller daily meetings as needed to look at specific populations, issues, or needs.
- Created a PHE data dashboard that will be refreshed daily and use historical data to develop an early-warning system.
- Established requirements for other reports that will be used to monitor and manage the unwinding, with close attention being paid to those with pending loss of coverage and what we can do to mitigate that. This data will be reviewed daily, and course corrections made as



needed.

- Developing ability to pause processes for certain populations if needed.
- Creating open lines with constituent services, our client assistance unit and call centers and our Medicaid Client Voice Council to more quickly learn of any brewing issues that need to be addressed. DHS social media manager also will monitor Medicaid-related pages for potential issues and raise those to leadership as needed.

Risk 7: Inability to process fair hearings timely due to a high volume of requests

The State considers the inability to process fair hearings timely as a moderate-to-high risk because of the potential for high volume. To mitigate that risk, DHS:

- Will be automatically moving to telephone hearings with the option for in-person hearing. Currently, telephone hearings are an option, but not the default approach.
- Spread out eligibility renewals in expectation that it will stagger potential fair hearing requests.
- Has implemented a new docketing system with templates and a database of frequently used language that will allow for uniformity in decisions.
- Has cross-trained staff in critical positions in case staffing needs to be adjusted.
- Developed electronic appeals management process to reduce reliance on paper files.
- Is developing a plan to hire additional legal and clerical support that is adequate for the expected increase in results. That could include use of contractors. Clerical support will be critical to managing the additional load as there are many clerical tasks in this process.
- Assessing processes that can be streamlined or altered to make the process more efficient.

Appendix B



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	A	B	C
1	BASELINE REPORT		
2	NAME OF STATE/TERRITORY:		
3	SUBMISSION DATE: MM/DD/YYYY		
4	UNWINDING PERIOD START DATE: MM/YYYY		
5	APPLICATION PROCESSING	NUMBER	STATE NOTES/ADDITIONAL INFORMATION ABOUT THE DATA
6	1. Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period (1a + 1b)		
7	1a. Pending MAGI and other non-disability applications		
8	1b. Pending disability-related applications		
9	RENEWALS	NUMBER	STATE NOTES/ADDITIONAL INFORMATION ABOUT THE DATA
10	2. Total beneficiaries enrolled as of the end of the month prior to the state's unwinding period		
11	STATE'S POLICY FOR COMPLETING RENEWALS	DESCRIPTION OF STATE'S RENEWAL TIMELINE POLICY	
12	3. State's timeline for the renewal process		
13	MEDICAID FAIR HEARINGS	NUMBER	STATE NOTES/ADDITIONAL INFORMATION ABOUT THE DATA
14	4. Total number of Medicaid fair hearings pending more than 90 days at the end of the month prior to the state's unwinding period		
15			
16			



Appendix C

of beneficiaries extended due to the continuous enrollment condition by category as of Dec. 29, 2022

Category of Assistance	Extensions
ARHOME	129,011
ARKids A	107,533
PCR	75,739
QMB	25,067
Newborn	29,275
SMB	13,931
SSI Medicaid	14,213
QI-1	6,865
Nursing Facility	4,057
ARChoices	2,882
ARSeniors	4,826
TEFRA	2,370
ARKids B	4,307
Adoption & Guardianship	1,771
Foster Care	2,549
Adult Medically Needy	1,551
DDS waiver	1,253
Workers with Disabilities	1,679
Pregnant Women - Limited	225
DAC	573
Assisted Living Facility	268
Pickle	218
Former Foster Care	216
PACE	135
OBRA 90	75
Pregnant Women - Full	93
Transitional Medicaid	105
Adult & AFDC EC Medically Needy Spenddown	96
Autism	57
AFDC U18 & UP Medically Needy	17
QDWI	3
Disabled Widower 50-59 (COBRA) & 60-65 (OBRA 87)	3

